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: 0049544

Facility Name: Heartland of Decatur

Address: 444 West Harrison St (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 877-7333 **Fax #** (217) 872-6723

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/17 to 05/31/18 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) 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 Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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 _____

	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	117	Skilled (SNF)	117	42,705	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	117	TOTALS	117	42,705	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	16,076	4,813	5,311	26,200	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,076	4,813	5,311	26,200	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.35%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 11/1/81

J. Was the facility purchased or leased after January 1, 1978?

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

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 117 and days of care provided 3,789

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	241,731	27,991	73,487	343,209		343,209		343,209			1
2	Food Purchase		216,608		216,608		216,608	(4)	216,604			2
3	Housekeeping	151,605	14,188	4,671	170,464		170,464		170,464			3
4	Laundry	22,659	11,419		34,078		34,078		34,078			4
5	Heat and Other Utilities			139,634	139,634	1,536	141,170		141,170			5
6	Maintenance	60,249	10,774	102,242	173,265		173,265		173,265			6
7	Other (specify):* Medical Waste			4,494	4,494		4,494		4,494			7
8	TOTAL General Services	476,244	280,980	324,528	1,081,752	1,536	1,083,288	(4)	1,083,284			8
	B. Health Care and Programs											
9	Medical Director			46,600	46,600		46,600		46,600			9
10	Nursing and Medical Records	2,156,744	148,596	536,159	2,841,499	35	2,841,534		2,841,534			10
10a	Therapy	507,101	6,147	26,713	539,961		539,961		539,961			10a
11	Activities	99,287	4,021	3,294	106,602		106,602		106,602			11
12	Social Services	144,568	1,322	3,509	149,399		149,399		149,399			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,907,700	160,086	616,275	3,684,061	35	3,684,096		3,684,096			16
	C. General Administration											
17	Administrative	78,697		393,499	472,196	(153,413)	318,783		318,783			17
18	Directors Fees											18
19	Professional Services			69,793	69,793		69,793	(69,793)				19
20	Dues, Fees, Subscriptions & Promotions			107,797	107,797		107,797	(34,653)	73,144			20
21	Clerical & General Office Expenses	369,666	58,947	330,227	758,840		758,840	(243,762)	515,078			21
22	Employee Benefits & Payroll Taxes			581,850	581,850	28,454	610,304		610,304			22
23	Inservice Training & Education			2,215	2,215		2,215		2,215			23
24	Travel and Seminar			30,768	30,768		30,768		30,768			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			426,041	426,041		426,041		426,041			26
27	Other (specify):*											27
28	TOTAL General Administration	448,363	58,947	1,942,190	2,449,500	(124,959)	2,324,541	(348,208)	1,976,333			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,832,307	500,013	2,882,993	7,215,313	(123,388)	7,091,925	(348,212)	6,743,713			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 Decatur #0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			219,324	219,324	9,432	228,756		228,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			502,384	502,384	113,956	616,340	(517,289)	99,051			32
33	Real Estate Taxes			101,366	101,366		101,366		101,366			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			77,300	77,300		77,300		77,300			35
36	Other (specify):*											36
37	**TOTAL Ownership**			900,374	900,374	123,388	1,023,762	(517,289)	506,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,937	850	134,787		134,787		134,787			39
40	Barber and Beauty Shops			1,050	1,050		1,050		1,050			40
41	Coffee and Gift Shops	29,062			29,062		29,062		29,062			41
42	Provider Participation Fee			199,627	199,627		199,627		199,627			42
43	Other (specify):* IV | X-Ray & Lab		14,247	17,454	31,701		31,701		31,701			43
44	**TOTAL Special Cost Centers**	29,062	148,184	218,981	396,227		396,227		396,227			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,861,369	648,197	4,002,348	8,511,914		8,511,914	(865,501)	7,646,413			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 Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4)	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	220	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(197)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,610)	21		18
19	Entertainment				19
20	Contributions	(1,402)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(65,674)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(229,601)	21		24
25	Fund Raising, Advertising and Promotional	(34,653)	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	(522,580)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (865,501)		$	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))**	$ (865,501)		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	Exeptional 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 Decatur

ID# 0049544

Report Period Beginning: 06/01/17

Ending: 05/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(1,172)	21	3
4	Donations Revenue	0	21	4
5	Accouning/Collection Fees	(4,119)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(517,289)	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**	(522,580)		49

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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
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	$ 355,717	HCR Manor Care Services, LLC	0.00%	$ 355,717	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,861,369	Heartland Employment Services, LLC	0.00%	3,861,369		4
5	V	10a	Therapy Management	12,279	HCR Manor Care Services, LLC	0.00%	12,279		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 4,229,365			$ 4,229,365	$ *	14

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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 Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				12
13			Manor Care of Hinsdale IL, LLC	Hinsdale				13
14			Manor Care of Homewood IL, LLC	Homewood				14
15			Manor Care of Libertyville IL, LLC	Libertyville				15
16			Manor Care of Naperville IL, LLC	Naperville				16
17			Manor Care of Northbrook IL, LLC	Northbrook				17
18			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				18
19			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				19
20			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				20
21			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				21
22			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				22
23			Manor Care of South Holland IL, LLC	South Holland				23
24			Manor Care of Westmont IL, LLC	Westmont				24
25			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				25
26			Arden Courts of Geneva IL, LLC	Geneva				26
27			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				27
28			Arden Courts of Northbrook IL, LLC	Northbrook				28
29			Arden Courts of Palos Heights IL, LLC	Palos Heights				29
30			Arden Courts of South Holland IL, LLC	South Holland				30

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	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 Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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 [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	8,211,545	$ 1,536	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	8,211,545	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	8,211,545	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	16,031	10,238	8,211,545	35	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	8,211,545	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	8,211,545	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	8,211,545	131,747	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	16,450,188	6,362,586	8,211,545	41,623	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	2,602,958	0	8,211,545	28,934	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	5,900,308	0	8,211,545	12,961	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	6,123,085	0	8,211,545	15,493	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	0	0	8,211,545	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	3,462,953	0	8,211,545	7,607	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	721,157	0	8,211,545	1,825	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	8,211,545	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,738,067,390		28,591,078		8,211,545	62,807	22
23	32	Directly Assigned Interest	Not Allocated			16,243,764			51,149	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,016,444				24
25	TOTALS					$ 174,800,957	$ 39,240,058		$ 355,717	25

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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**		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						$ 738,560	$ 660,924		0.0774	$ 51,149	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										62,807	6
7	Interest Income / Interest Expense										(14,905)	7
8												8
9	TOTAL Facility Related						$ 738,560	$ 660,924			$ 99,051	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 738,560	$ 660,924			$ 99,051	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 Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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.**	$ 95,445	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.)		$ 103,149	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,704	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,662	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.		$ 101,366	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	92,911	8
2014	91,876	9
2015	98,943	10
2016	104,122	11
2017	102,176	12

Line 2: $103,149 = $52,061 for 2nd half 2016 + $51,088 for 1st half 2017

Line 4: $93,797= $51,162 for 2nd half 2017 + $42,635 for Jan - May 2018

	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 of Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0049544

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 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.	04-12-03-451-010	See Attached	$ 98,885.62	$ 98,885.62
2.	04-12-03-451-012	See Attached	$ 1,487.40	$ 1,487.40
3.	04-12-03-451-013	See Attached	$ 146.64	$ 146.64
4.	04-12-03-451-016	See Attached	$ 1,656.76	$ 1,656.76
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 102,176.42	$ 102,176.42

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 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 of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,542 B. General Construction Type: Exterior Masonry Frame Steel 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		1981, 2005/06	$ 411,449	1
2			2009	45,126	2
3	TOTALS			$ 456,575	3

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	84			1963	$ 659,655	$ 53,232		$ 53,232	$	$ 2,621,944	4
5	10			2002	480,558						5
6	23			2005	1,072,957						6
7	7/1/06 Capital Rate Adj #1			2005	259,992						7
8	Therapy Addition			2009	743,129						8
	Improvement Type**										
9	Current Year Depreciation					107,780		107,780		2,824,051	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15	RETIREMENTS			1987	(86,079)						15
16				1988	38,377						16
17				1989	18,196						17
18				1990	6,261						18
19				1991	162,665						19
20	RETIREMENTS			1991	(3,037)						20
21				1992	121,887						21
22	RETIREMENTS			1992	(6,084)						22
23				1993	191,712						23
24				1994	75,641						24
25	Consolidated 1995 Assets			1995	113,891						25
26	Consolidated1996 Assets			1996	49,186						26
27	Consolidated 1997 Assets			1997	69,918						27
28	Consolidated 1998 Assets			1998	168,373						28
29	Consolidated 1999 Assets			1999	34,171						29
30	Consolidated 2000 Assets			2000	122,059						30
31	Consolidated 2001 Assets			2001	106,737						31
32	Consolidated 2002 Assets			2002	107,434						32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	Renovation-Roofing & Sheet Metal	2003	$ 67,148	$		$	$	$	37
38	Renovation-General Overhead	2003	1,031						38
39	7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						39
40	Renovation-Interest	2003	581						40
41	7/1/06 CAPITAL RATE ADJ #4	2003	(581)						41
42	AWNING	2003	2,470						42
43	Landscaping-Install Façade Materials	2003	23,984						43
44	GAZEBO	2003	6,215						44
45	ADD'L COST GAZEBO	2003	2,611						45
46	Renovation-Engineering	2004	4,880						46
47	Renovation-General Overhead	2004	10,453						47
48	7/1/06 Capital Rate Adj #5	2004	(10,453)						48
49	Renovation-Interest	2004	138						49
50	7/1/06 Capital Rate Adj #6	2004	(138)						50
51	Doors and Downspouts	2004	7,110						51
52	Doors Retainage	2004	790						52
53	Vinyl Tile and Cove Base	2004	17,910						53
54	Vinyl Tile and Base	2005	2,974						54
55	7/1/06 Capital Rate Adj #7	2005	(2,974)						55
56	Vinyl Tile	2005	2,974						56
57	7/1/06 Capital Rate Adj #7	2005	(2,974)						57
58	Vinyl Tile and Cove Base	2005	10,985						58
59	Water/Sewer/Utilities	2005	76,296						59
60	7/1/06 Capital Rate Adj #8	2005	(76,296)						60
61	Paving/Parking	2005	45,064						61
62	7/1/06 Capital Rate Adj #9	2005	(45,064)						62
63	Site Concrete	2005	20,963						63
64	7/1/06 Capital Rate Adj #10	2005	(20,963)						64
65	Site Preparation	2005	50,580						65
66	7/1/06 Capital Rate Adj #11	2005	(50,580)						66
67	Fencing/Gazebo/Courtyard	2005	13,234						67
68	7/1/06 Capital Rate Adj #12	2005	(13,234)						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,865,892	$ 161,012		$ 161,012	$	$ 5,445,995	70

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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		$ 4,865,892	$ 161,012		$ 161,012	$	$ 5,445,995	1
2	Landscaping	2005	30,808						2
3	7/1/06 Capital Rate Adj #13	2005	(30,808)						3
4	Site Demolition	2005	25,400						4
5	7/1/06 Capital Rate Adj #17	2005	(25,400)						5
6	Water/Sewer Testing	2005	9,025						6
7	Landscaping	2005	10,269						7
8	7/1/06 Capital Rate Adj #14	2005	(10,269)						8
9	Landscaping	2005	1,838						9
10	7/1/06 Capital Rate Adj #15	2005	(1,838)						10
11	Nursing Station Carpentry	2005	3,360						11
12	Vinyl Wall Covering	2005	1,344						12
13	Architect & Engineering Fees	2005	150,302						13
14	7/1/06 Capital Rate Adj #18	2005	(13,833)						14
15	General Overhead & Interest	2005	221,331						15
16	7/1/06 Capital Rate Adj #19	2005	(221,331)						16
17	Permit Fees, Plan Reviews	2005	15,128						17
18	7/1/06 Capital Rate Adj #16	2005	(9,600)						18
19	Vinyl Wall Covering, Flooring	2005	34,342						19
20	Vinyl Wall Covering	2005	1,551						20
21	Carpet	2005	3,680						21
22	Canopy Sprinklers	2005	3,950						22
23	Blinds	2005	2,375						23
24	Vinyl Wall Covering	2005	(676)						24
25	Fabrics	2005	498						25
26	Flooring	2005	14,253						26
27	Overhead & Interest	2005	1,641						27
28	7/1/06 Capital Rate Adj #20	2005	(1,641)						28
29	Carpentry	2005	26,507						29
30	Doors	2006	624						30
31	HVAC	2006	5,715						31
32	Painting	2006	16,890						32
33	Rooftop Unit	2006	2,325						33
34	TOTAL (lines 1 thru 33)		$ 5,133,652	$ 161,012		$ 161,012	$	$ 5,445,995	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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		$ 5,133,652	$ 161,012		$ 161,012	$	$ 5,445,995	1
2	Rooftop Unit	2006	10,910						2
3	Demolish & Reinstall Floors	2006	30,700						3
4	Ductwork	2006	1,163						4
5	Electrical	2006	4,176						5
6	Wallcovering, Painting	2006	2,187						6
7	Fence	2006	9,983						7
8	ENGINEERING FOR ENTRANCE	2007	1,425						8
9	EXTERIOR SIGN	2008	4,344						9
10	SEWER LINE	2008	707						10
11	SEWER LINE	2008	6,364						11
12	0407 RESI RM CORR OFFICE RENO	2008	7,619						12
13	0407 RESI RM CORR OFFICE RENO	2008	39,580						13
14	3 TON UNIT	2008	4,358						14
15	100 AMP PANEL	2008	1,986						15
16	ADJ HOT WATER SYS (ASSET 1903)	2008	7,947						16
17	1308 2 HOT WATER SYSTEM	2008	2,078						17
18	1308 2 HOT WATER SYSTEM	2008	302						18
19	1308 2 HOT WATER SYSTEM	2008	73,200						19
20	PT, BLD IM - ARCH, ENG & DEV COSTS	2009	120,617						20
21	PT, BLD IM - DEV GENL O-H	2009	54,958						21
22	PT, BLD IM - INT ON CONSTRUCTION	2009	13,277						22
23	PT, BLD IM - CARPET & PADS	2009	1,847						23
24	PT, BLD IM - WALL COVERINGS	2009	7,844						24
25	RETAINING WALL	2008	2,900						25
26	PAVING/SEALCOATING	2008	6,210						26
27	PT, LI - DEV COSTS	2009	44,176						27
28	PT, LI - GEN'L CONTRACTOR	2009	116,991						28
29	PT Addition - GEN'L CONTRACTOR	2009	13,771						29
30	PT Addition - Arch & Eng. Costs	2009	3,719						30
31	PT Addition - Wallcovering & Guards	2009	583						31
32	PT Addition - Electrical	2009	7,390						32
33	PT Addition - Arch & Eng. Costs	2009	962						33
34	TOTAL (lines 1 thru 33)		$ 5,737,926	$ 161,012		$ 161,012	$	$ 5,445,995	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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		$ 5,737,926	$ 161,012		$ 161,012	$	$ 5,445,995	1
2	Fire proof Mechanical room ceiling	2010	8,881						2
3	Carpet (6 private rooms. 123, 152, 160-163)	2010	6,879						3
4	Wallcovering & Paint (Dining Rm, Main Shower, Resident Rms.)	2010	23,000						4
5	Heating element for roof top unit	2011	1,661						5
6	Replace 110 receptacles (electric outlets) in resident rooms	2011	6,050						6
7	Replace concrete walk in court yard	2011	4,230						7
8									8
9	Awning on front of building	2012	2,055						9
10	Metal Door	2012	2,715						10
11									11
12	Build closests/shelves in Dinning & Activities Rooms	2013	23,612						12
13	Doors(5) and Closers(15) for resident rooms	2013	23,194						13
14	Parking Addition, 18 spaces - Concrete	2013	94,060						14
15	Light fixture upgrade - whole building	2014	15,631						15
16	Pavilion Structure	2014	10,933						16
17	2 SINK PLUMBING for new kidney dialysis room	2013	6,455						17
18	85 Gal H/W Tank Upgrade	2014	29,602						18
19									19
20	install video intercom @ nurses stations 1 - 2, front, reception & arcadia doors.								20
21	Install securecare @ SVC corridor	2014	14,332						21
22	emergency pwr @ empl exit, sunnyside dining, patio gate, front/back nurses stations								22
23	back/front med rm, admin, PR, DON ofcs, & Phone rm	2015	18,356						23
24									24
25	PAINT-dining rm & res rm baths	2015	14,116						25
26	renov- painting, carpeting & pads, wallcovering in lobby/vestibule, front/back nurse's								26
27	stations, and all hallways throught bldg	2015	108,840						27
28	Data Drop	2015	1,157						28
29	renovation - resilient flooring in lobby/vestibule, front/back nurse's								29
30	stations, and all hallways throught bldg	2015	137,286						30
31	repair collapsed sewer & water lines to bldg	2015	15,685						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,306,656	$ 161,012		$ 161,012	$	$ 5,445,995	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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		$ 6,306,656	$ 161,012		$ 161,012	$	$ 5,445,995	1
2	Renovation - Wallcovering & Corner Guards	2015	49,729						2
3	Security Cameras @ front & back nurses stations	2015	5,115						3
4	Life Safety Corrections for Generator: new 100 amp main breaker in ancillary storage rm, run conduit to LS panel								4
5	from transfer switch outside of boiler rm. Fire stop	2015	19,200						5
6	repair/replce 6'x6' area of water damaged kitchen ceiling	2015	2,650						6
7	Paint 14 baths: 106, 108, 111-114, 166, 161-162, 151, 145, 122, 120, 124								7
8	& 2 resident rms: 166 & 168	2016	4,100						8
9									9
10	Wall/floor tile in 2 shower stalls	2016	6,239						10
11	2 metal fire doors & hardware in corridor by breakroom	2016	4,340						11
12	Wall/floor tile in shower stall	2017	3,950						12
13									13
14	Front porch columns (4)	2017	8,240						14
15	Metal door and frame in service corridor	2017	6,800						15
16	Carpet in Arcadia corridor, lounge and office.	2017	4,564						16
17	Carpet installation in Arcadia corridor, lounge and office.	2017	2,734						17
18	1 Hour Smoke Wall for Arcadia Unit	2017	7,500						18
19	1 Hour Smoke Wall installation in Arcadia Unit	2017	22,674						19
20	Dry head sprinklers in kitchen and dry storage area	2018	2,850						20
21	Condenser cycling fan switch for kitchen walk in cooler	2018	2,500						21
22	Maglock/Securecom locking system at front entrance	2018	3,934						22
23	BTR 500-120 Water Heater in South Boiler Room	2018	19,108						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)		$ 6,482,883	$ 161,012		$ 161,012	$	$ 5,445,995	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	$ 2,148,680	$ 58,312	$ 58,312	$		$ 1,981,353	71
72	Current Year Purchases	30,041						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			9,432	9,432			74
75	TOTALS	$ 2,178,721	$ 58,312	$ 67,744	$ 9,432		$ 1,981,353	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)	$ 9,118,179	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,324	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,756	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,432	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,427,348	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 Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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: $ 77,300 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			$	$	17
18					18
19					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 & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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

   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 of Decatur

STATE OF ILLINOIS
0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	1,939 hrs	$ 88,855	102	$ 8,138	$ 222	2,041	$ 97,215	1
2	Licensed Speech and Language Development Therapist	10a	1305 hrs	59,795			370	1,305	60,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2055 hrs	94,157			5,555	2,055	99,712	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				133,937		133,937	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3			221	17,580		221	17,580	12
13	Other (specify): X-Ray & Lab | IV	43, 2 & 3				17,454	14,247		31,701	13
14	TOTAL			$ 242,807	323	$ 43,172	$ 154,331	5,622	$ 440,310	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/18 (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	$ 1,544	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (322,318))	506,692		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,421		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 524,657	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,575		13
14	Buildings, at Historical Cost	6,482,883		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,178,721		16
17	Accumulated Depreciation (book methods)	(7,427,348)		17
18	Deferred Charges	125,983		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	57,765		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,874,579	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,399,236	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 187,925	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,061		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,662		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	143,867		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 677,515	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	660,924		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)**	$ 660,924	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,338,439	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,060,797	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,399,236	$	48

*(See instructions.)

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,723,238	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,723,238	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,996,660)	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)**	$ (2,996,660)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	2,334,219	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,334,219	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,060,797	24 *

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	$ 6,011,258	1
2	Discounts and Allowances for all Levels	(2,063,670)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,947,588	3
	B. Ancillary Revenue		
4	Day Care	1,232,312	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,232,312	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	1,172	12
13	Barber and Beauty Care	984	13
14	Non-Patient Meals	4	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,219	19
20	Radiology and X-Ray	11,586	20
21	Other Medical Services	28,198	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 335,574	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount	(220)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (220)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,515,254	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,081,752	31
32	Health Care	3,684,061	32
33	General Administration	2,449,500	33
	B. Capital Expense		
34	Ownership	900,374	34
	C. Ancillary Expense		
35	Special Cost Centers	196,600	35
36	Provider Participation Fee	199,627	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,511,914	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,996,660)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,996,660)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,313,096	44
45	Private Pay - Net Inpatient Revenue	963,271	45
46	Medicare - Net Inpatient Revenue	579,436	46
47	Other-(specify) Hospice	132,682	47
48	Other-(specify) Insurance	(40,897)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,947,588	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.**

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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	1,224	1,316	$ 55,337	$ 42.05	1
2	Assistant Director of Nursing	3,973	4,272	142,540	33.37	2
3	Registered Nurses	10,892	11,711	372,673	31.82	3
4	Licensed Practical Nurses	23,220	24,966	596,251	23.88	4
5	CNAs & Orderlies	60,980	65,564	958,305	14.62	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	7,703	8,263	378,702	45.83	7
8	Rehab/Therapy Aides	3,640	3,905	128,399	32.88	8
9	Activity Director	7,106	7,643	99,287	12.99	9
10	Activity Assistants					10
11	Social Service Workers	5,636	6,066	144,568	23.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,825	20,243	241,731	11.94	15
16	Dishwashers					16
17	Maintenance Workers	2,617	2,799	60,249	21.53	17
18	Housekeepers	11,935	12,835	151,605	11.81	18
19	Laundry	1,992	2,142	22,659	10.58	19
20	Administrator	2,080	2,080	78,697	37.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,124	17,290	369,666	21.38	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	2,202	2,370	31,638	13.35	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,916	2,066	29,062	14.07	33
34	TOTAL (lines 1 - 33)	182,065	195,531	$ 3,861,369 *	$ 19.75	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	46,600	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)		$ 46,600		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,535	$ 94,683	10, 3	50
51	Licensed Practical Nurses	4,898	239,998	10, 3	51
52	Certified Nurse Assistants/Aides	3,787	96,332	10, 3	52
53	TOTAL (lines 50 - 52)	10,220	$ 431,013		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn Job (Jun - Jan)	Administrator	0	$ 61,242
Raymond Campbell (May)	Administrator	0	13,302
Kevin Meals (May)	Administrator	0	4,153
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,697

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 355,717
Cheryl Vittorio (Jan -May)	37,782
TOTAL (agree to Schedule V, line 17, col. 3)	$ 393,499
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 65,674
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	4,119
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)		$ 69,793

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,671
Unemployment Compensation Insurance	48,389
FICA Taxes	278,379
Employee Health Insurance	189,966
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	13,373
Appreciation, Oth Benefits & Mktg Adj	16,306
Tuition Program	2,138
SMSP Match	157
Employee Uniforms	11,471
Home Office Allocation	28,454
TOTAL (agree to Schedule V, line 22, col.8)	$ 610,304

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	48,216
Health Care Worker Background Check	
(Indicate # of checks performed 560)	11,478
Patient Background Checks 163	1,630
Dues & Subscriptions	3,279
Association Dues	7,336
Advertising	32,525
Other Licenses and Permits	1,343
Less: Non-Allowable Association Dues	(2,128)
Less: Public Relations Expense	( )
Non-allowable advertising	(32,525)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,144

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	30,768
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)	$ 30,768

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/17 Ending: 05/31/18

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. **IHCA $3491 & AHCA $1717**

(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. $ **42,844** 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. $ **199,627**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **4**

(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