

		FOR BHF USE					

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**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0055517</u></p> <p><b>Facility Name:</b> <u>Heartland Nursing Rehab</u></p> <p><b>Address:</b> <u>410 Northwest 3rd St</u> <u>Casey</u> <u>62420</u>        Number City Zip Code</p> <p><b>County:</b> <u>Clark</u></p> <p><b>Telephone Number:</b> <u>(217) 932-4081</u> Fax # <u>(217) 932-4922</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>3/1/2019</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>        Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>        Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Heartland Nursing Rehab

# 0055517 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

**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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	81	Skilled (SNF)	81	29,646	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	29,646	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,595	3,595	8
9	SNF/PED					9
10	ICF	7,384	5,433		12,817	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,384	5,433	3,595	16,412	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 55.36%

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

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**  
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  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

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

**I. On what date did you start providing long term care at this location?**  
Date started 3/1/19

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 3/1/19 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 35 and days of care provided 3,356

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Heartland Nursing Rehab # 0055517 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	168,988	8,772	5,127	182,887		182,887		182,887		1
2	Food Purchase		96,309		96,309		96,309		96,309		2
3	Housekeeping	111,000	8,965		119,965		119,965	436	120,401		3
4	Laundry	53,436	4,668		58,104		58,104		58,104		4
5	Heat and Other Utilities			114,482	114,482		114,482	467	114,949		5
6	Maintenance	53,562	4,667	22,837	81,066		81,066	1,088	82,154		6
7	Other (specify):* <b>Waste Removal</b>			12,238	12,238		12,238	50	12,288		7
8	<b>TOTAL General Services</b>	<b>386,986</b>	<b>123,381</b>	<b>154,684</b>	<b>665,051</b>		<b>665,051</b>	<b>2,041</b>	<b>667,092</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,100	9,100		9,100		9,100		9
10	Nursing and Medical Records	1,117,900	58,973	1,200	1,178,073		1,178,073	992	1,179,065		10
10a	Therapy			1,470	1,470		1,470		1,470		10a
11	Activities	44,487	596	1,792	46,875		46,875		46,875		11
12	Social Services	37,836		1,120	38,956		38,956		38,956		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>WLC Benefits Alloc</b>							114	114		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,200,223</b>	<b>59,569</b>	<b>14,682</b>	<b>1,274,474</b>		<b>1,274,474</b>	<b>1,106</b>	<b>1,275,580</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	86,292		215,117	301,409		301,409	(198,040)	103,369		17
18	Directors Fees										18
19	Professional Services			48,874	48,874		48,874	330	49,204		19
20	Dues, Fees, Subscriptions & Promotions			14,712	14,712		14,712	(2,568)	12,144		20
21	Clerical & General Office Expenses	72,135	10,101	18,707	100,943		100,943	32,581	133,524		21
22	Employee Benefits & Payroll Taxes			216,377	216,377		216,377		216,377		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,773	1,773		1,773	13	1,786		24
25	Other Admin. Staff Transportation			4,695	4,695		4,695	649	5,344		25
26	Insurance-Prop.Liab.Malpractice			85,260	85,260		85,260	609	85,869		26
27	Other (specify):* <b>WLC Benefits Alloc</b>							5,779	5,779		27
28	<b>TOTAL General Administration</b>	<b>158,427</b>	<b>10,101</b>	<b>605,515</b>	<b>774,043</b>		<b>774,043</b>	<b>(160,647)</b>	<b>613,396</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,745,636</b>	<b>193,051</b>	<b>774,881</b>	<b>2,713,568</b>		<b>2,713,568</b>	<b>(157,500)</b>	<b>2,556,068</b>		<b>29</b>

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Heartland Nursing Rehab

#0055517

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			154,905	154,905		154,905	(58,271)	96,634			30
31	Amortization of Pre-Op. & Org.							211	211			31
32	Interest			112,250	112,250		112,250	(60)	112,190			32
33	Real Estate Taxes			39,218	39,218		39,218	328	39,546			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,591	12,591		12,591	45	12,636			35
36	Other (specify):* Loan Cost Amort			13,451	13,451		13,451		13,451			36
37	<b>TOTAL Ownership</b>			332,415	332,415		332,415	(57,747)	274,668			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,729	408,582	458,311		458,311		458,311			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,090	135,090		135,090		135,090			42
43	Other (specify):* Disallowed Costs			72,919	72,919		72,919	(72,919)				43
44	<b>TOTAL Special Cost Centers</b>		49,729	616,591	666,320		666,320	(72,919)	593,401			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,745,636	242,780	1,723,887	3,712,303		3,712,303	(288,166)	3,424,137			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(2,932)	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	(69,661)	30		9
10	Interest and Other Investment Income	(106)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	43		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	(2,818)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,922)	43		24
25	Fund Raising, Advertising and Promotional	(13,533)	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 Page 5A	(2,089)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (147,109)		\$	30

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	2	
		Amount	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)	(141,057)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (141,057)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (288,166)		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Heartland Nursing Rehab

ID# 0055517

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (484)	43	1
2	Miscellaneous income offset	(1,592)	21	2
3	Nonallowable Real Estate Taxes	(13)	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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16				16
17				17
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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	<b>Total</b>	(2,089)		49

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
Scott Stout	100	See Page 6 Supp		WLC Management Fir	Harrisburg	Management Co.

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  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 436	\$ 436	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	467	467	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	1,088	1,088	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	50	50	4
5	V	10 Nursing and Medical Records		WLC Management Firm, LLC	100.00%	992	992	5
6	V	15 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	114	114	6
7	V	17 Administrative	215,117	WLC Management Firm, LLC	100.00%	17,077	(198,040)	7
8	V	19 Professional Services		WLC Management Firm, LLC	100.00%	330	330	8
9	V	20 Dues, Fees, Subs & Prom		WLC Management Firm, LLC	100.00%	250	250	9
10	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	34,173	34,173	10
11	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	13	13	11
12	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	649	649	12
13	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	609	609	13
14	Total		\$ 215,117			\$ 56,248	\$ * (158,869)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27 Mgmt Allocation of Benefits	\$	WLC Management Firm, LLC	100.00%	\$ 5,779	\$	5,779	15
16	V	30 Depreciation		WLC Management Firm, LLC	100.00%	11,390		11,390	16
17	V	31 Amortization		WLC Management Firm, LLC	100.00%	211		211	17
18	V	32 Interest		WLC Management Firm, LLC	100.00%	46		46	18
19	V	33 Real Estate Taxes		WLC Management Firm, LLC	100.00%	341		341	19
20	V	35 Equipment Rental		WLC Management Firm, LLC	100.00%	45		45	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 17,812	\$ *	17,812	39

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number

Heartland Nursing Rehab

# 005517

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Alhambra Rehab and Healthcare	Alhambra	Acorn Estates	Mount Carmel	Supportive Living	1
2			Carrier Mills Nursing & Rehab Center	Carrier Mills				2
3			Duquoin Nursing & Rehabilitation Center	Duquoin				3
4			Eldorado Rehab and Healthcare	Eldorado				4
5			Fairview Rehab and Healthcare	DuQuoin				5
6			Greenville Nursing and Rehab Center	Greenville				6
7			Oakview Nursing and Rehab	Mt Carmel				7
8			Pinckneyville Nursing and Rehab Center	Pinckneyville				8
9			Saline Care Nursing and Rehab Center	Harrisburg				9
10			Stonebridge Nursing and Rehab Center	Benton				10
11								11
12								12
13								13
14								14
15								15
16								16
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28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Heartland Nursing Rehab

# 0055517

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	2.73	6.83	Alloc. Salary	\$ 17,077	L17, C7	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	\$ 17,077		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Heartland Nursing Rehab

# 005517

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

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

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

Name of Related Organization WLC Management Firm, LLC  
 Street Address 215 East Locust Street  
 City / State / Zip Code Harrisburg, IL 62946  
 Phone Number ( 618 ) 294-8696  
 Fax Number ( 618 ) 294-8699

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Weightd Avg Census 240,729	12	\$ 6,399	\$ 6,399	16,412	\$ 436	1
2	5	Utilities	Weightd Avg Census 240,729	12	6,853		16,412	467	2
3	6	Maintenance	Weightd Avg Census 240,729	12	15,959		16,412	1,088	3
4	7	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	734		16,412	50	4
5	10	Nursing and Medical Records	Weightd Avg Census 240,729	12	14,557	14,557	16,412	992	5
6	15	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	1,669		16,412	114	6
7	17	Administrative	Weightd Avg Census 240,729	12	250,490	250,490	16,412	17,077	7
8	19	Professional Services	Weightd Avg Census 240,729	12	4,836		16,412	330	8
9	20	Dues, Fees, Subscriptions & Prom	Weightd Avg Census 240,729	12	3,667		16,412	250	9
10	21	Clerical & General Office	Weightd Avg Census 240,729	12	501,243	488,721	16,412	34,173	10
11	24	Travel & Seminar	Weightd Avg Census 240,729	12	179		16,412	13	11
12	25	Other Admin Staff Transport	Weightd Avg Census 240,729	12	9,524		16,412	649	12
13	26	Insurance-Prop/Liab/Malprac	Weightd Avg Census 240,729	12	8,930		16,412	609	13
14	27	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	84,770		16,412	5,779	14
15	30	Depreciation	Weightd Avg Census 240,729	12	167,061		16,412	11,390	15
16	31	Amortization	Weightd Avg Census 240,729	12	3,096		16,412	211	16
17	32	Interest	Weightd Avg Census 240,729	12	673		16,412	46	17
18	33	Real Estate Taxes	Weightd Avg Census 240,729	12	5,000		16,412	341	18
19	35	Equipment Rental	Weightd Avg Census 240,729	12	653		16,412	45	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,086,293	\$ 760,167		\$ 74,060	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Heartland Nursing Rehab

# 0055517

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Legence Bank		X	Facility Purchase	\$9,797.48	6/14/19	\$ 1,382,400	\$ 1,323,509	6/30/24	5.7500	\$ 110,960	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Legence Bank		X	Line of Credit		11/27/19	370,491		6/30/21	4.7500	1,290	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$9,797.48		\$ 1,752,891	\$ 1,323,509			\$ 112,250	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11										Interest Income Offset	(106)	11						
12										WLC Mgmt Allocation	46	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (60)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,752,891	\$ 1,323,509			\$ 112,190	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 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.)	2019	\$	<b>39,205</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>39,205</b>	3
4. Real Estate Tax accrual used for 2020 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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.			<b>341</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>341</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>39,546</b>	7

  

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	_____	8	
	2016	_____	9	
	2017	_____	10	
	2018	_____	11	
	2019	<b>39,205</b>	12	

  

	<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2019	\$		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.**

SEE ACCOUNTANTS' PREPARATION REPORT

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heartland Nursing Rehab COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0055517

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-19-00-200-003</u>	<u>Long Term Care Property</u>	\$ <u>37,019.96</u>	\$ <u>37,019.96</u>
2. <u>03-11-19-08-203-049</u>	<u>Long Term Care Property</u>	\$ <u>2,185.46</u>	\$ <u>2,185.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>39,205.42</u></u>	\$ <u><u>39,205.42</u></u>

**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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**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 Nursing Rehab

# 0055517 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO

If so, please complete the following:

1. Total Amount Incurred: Allocated from Mgmt Co 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 211 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 152,472, 2019, \$ 100,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 152,472, (blank), \$ 100,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		2019		\$ 800,000	\$	25	\$ 32,000	\$ 32,000	\$ 48,000
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Remodel Resident Rooms, Hallways and Dining Area:		2019	230,214		20	11,511	11,511	17,266
10	Repair, Patch, Prime and Paint Walls/ Level Floor/ Install								
11	New Flooring and Cove Base/Repair Doors and Trim/								
12	Replace Ceiling Tiles as Needed/ Doors/ Signs/ Lighting								
13	Blinds/ Rolling Fire Shutter								
14	New Landscaping		2019	6,665		20	333	333	500
15	New 100 Gallon Hot Water Heater		2019	4,261		20	213	213	320
16	New 100 Gallon Hot Water Heater		2020	5,047		20	126	126	126
17	Remodel Resident Rooms, Hallways and Dining Area Continued:								
18	Repair, Patch, Prime and Paint Walls/ Level Floor/ Install								
19	New Flooring and Cove Base/Repair Doors and Trim/								
20	Replace Ceiling Tiles as Needed/ Doors/ Signs/ Lighting								
21	Blinds		2020	80,851		20	2,021	2,021	2,021
22									
23									
24									
25									
26									
27									
28									
29	Allocated from WLC Management		2018	25,358		15-39	1,082	1,082	11,971
30	Allocated from WLC Management		2020	8,869		15	296	296	296
31									
32									
33	Financial Statement Depreciation				154,905			(154,905)	
34									
35									
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  
SEE ACCOUNTANTS' PREPARATION REPORT



XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,161,265	\$ 154,905		\$ 47,582	\$ (107,323)	\$ 80,500	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 414,350	\$	\$ 41,435	\$ 41,435	10 yrs	\$ 62,153	71
72	Current Year Purchases	21,248		1,062	1,062	10 yrs	1,062	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	305					305	74
75	TOTALS	\$ 435,903	\$	\$ 42,497	\$ 42,497		\$ 63,520	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	Facility	2017 Dodge Grand Caravan	2020	\$ 27,246	\$	\$ 3,406	\$ 3,406	4 yrs	\$ 3,406	76
77										77
78	Allocated from WLC Mgmt			15,579		3,149	3,149		15,579	78
79										79
80	TOTALS			\$ 42,825	\$	\$ 6,555	\$ 6,555		\$ 18,985	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)	\$ 1,739,993	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,905	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,634	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,271)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 163,005	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Heartland Nursing Rehab

# 0055517

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

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

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.	_____ /2020	\$ _____
13.	_____ /2021	\$ _____
14.	_____ /2021	\$ _____

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 \_\_\_\_\_.

\_\_\_\_\_ N/A  
\_\_\_\_\_ N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 12,636 Description: Medical Equipment \$7,459; Office Equip/Storage \$5,132; HO Allocation \$45

(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	N/A		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3), 39(3)	hrs	\$	6,833	\$ 121,117	\$	6,833	\$ 121,117	1	
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs		3,987	73,790		3,987	73,790	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		13,081	208,387		13,081	208,387	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 prescripts				49,729		49,729	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	23,901	\$ 403,294	\$ 49,729	23,901	\$ 453,023	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Heartland Nursing Rehab

# 0055517

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 573,729	\$ 573,729	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,769 )	1,130,888	1,130,888	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,234	7,234	6
7	Other Prepaid Expenses	29,720	29,720	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,741,571	\$ 1,741,571	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,152,722	1,161,265	15
16	Equipment, at Historical Cost	438,142	478,728	16
17	Accumulated Depreciation (book methods)	(829,326)	(163,005)	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 (specify):			22
23	Other(specify): <u>Goodwill / Loan Costs</u>	175,984	175,984	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,037,522	\$ 1,752,972	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,779,093	\$ 3,494,543	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 72,358	\$ 72,358	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,066	56,066	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,493	27,493	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	50	50	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 155,967	\$ 155,967	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,323,509	1,323,509	40
41	Bonds Payable			41
42	Deferred Compensation	711,679	711,679	42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,035,188	\$ 2,035,188	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,191,155	\$ 2,191,155	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 587,938	\$ 1,303,388	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,779,093	\$ 3,494,543	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>94,153</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustments - Depreciation &amp; Amortization</b>	<b>(241,057)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(146,904)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>756,610</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(21,768)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>734,842</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>587,938</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Heartland Nursing Rehab

# 0055517

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**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.**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,266,863	1
2	Discounts and Allowances for all Levels	864,804	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,131,667	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	208,057	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 208,057	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	119,148	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,157	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29	19
20	Radiology and X-Ray		20
21	Other Medical Services	(843)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 127,491	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	106	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 106	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	1,592	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,592	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,468,913	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	665,051	31
32	Health Care	1,274,474	32
33	General Administration	774,043	33
<b>B. Capital Expense</b>			
34	Ownership	332,415	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	531,230	35
36	Provider Participation Fee	135,090	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,712,303	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	756,610	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 756,610	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,140,328	44
45	Private Pay - Net Inpatient Revenue	1,027,025	45
46	Medicare - Net Inpatient Revenue	1,925,716	46
47	Other-(specify) <u>Insurance</u>	38,598	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,131,667	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Heartland Nursing Rehab

# 0055517

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,706	\$ 65,911	\$ 36.50	1
2	Assistant Director of Nursing				2
3	Registered Nurses	8,598	302,700	33.44	3
4	Licensed Practical Nurses	10,948	240,095	20.38	4
5	CNAs & Orderlies	31,564	509,194	15.41	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,021	26,049	11.68	9
10	Activity Assistants	1,664	18,438	10.72	10
11	Social Service Workers	2,530	37,836	14.30	11
12	Dietician				12
13	Food Service Supervisor	2,194	40,307	17.22	13
14	Head Cook				14
15	Cook Helpers/Assistants	11,292	128,681	10.95	15
16	Dishwashers				16
17	Maintenance Workers	2,978	53,562	15.88	17
18	Housekeepers	10,606	111,000	10.04	18
19	Laundry	4,570	53,436	10.67	19
20	Administrator	2,468	86,292	33.80	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	4,296	72,135	15.17	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				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	97,435	\$ 1,745,636 *	\$ 16.93	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	107	\$ 5,127	L1, C3	35
36	Medical Director	Monthly	9,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	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	31	1,792	L11, C3	44
45	Social Service Consultant	22	1,120	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	160	\$ 18,339		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Penny Chrysler	Administrator	0	\$ 67,787	Workers' Compensation Insurance	\$ 29,117	IDPH License Fee	\$ 1,990		
Merle Taylor	Admin Reg Exec	0	17,605	Unemployment Compensation Insurance	15,457	Advertising: Employee Recruitment	609		
Lon Linder	VP Operations	0	900	FICA Taxes	127,995	Health Care Worker Background Check (Indicate # of checks performed <u>11</u> )	620		
				Employee Health Insurance	32,935	Patient Background Checks <u>26</u>	468		
				Employee Meals	831	License & Permits	710		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,106		
				Employee Physicals/Drug Tests	3,630	IHCA	7,209		
				Life/Disability Insurance	3,914				
				Other Employee Benefits	2,498				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,292			Allocated From WLC Mgmt Firm	250		
B. Administrative - Other						Less: Public Relations Expense	(2,818)		
Description			Amount			Non-allowable advertising ( )			
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 215,117			Yellow page advertising ( )			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 215,117	TOTAL (agree to Schedule V, line 22, col.8)		\$ 216,377	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,144
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
E-Solutions, Inc.	Health Info Management		\$ 1,450				Out-of-State Travel	\$	
American Healthtech	LTC Software		31,571						
Information Controls	Payroll Service		4,734				In-State Travel		
Prime Care Technologies	Computer Services		4,024						
Templin Healthcare Accounting	Accounting Services		4,980				Seminar Expense	1,773	
Kemper CPA Group	Accounting Services		2,115				Allocated From WLC Mgmt Firm	13	
							Entertainment Expense ( )		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 48,874	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,786

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name &amp; ID Number Heartland Nursing Rehab

# 0055517

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**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. 7,209 IHCA
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,178 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? No  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 135,090  
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. \$ 831 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 100% Line 14  
d. Have vehicle usage logs been maintained? Yes  
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: \_\_\_\_\_
- (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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' PREPARATION REPORT**