FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0049460

Facility Name: Heartland of Galesburg

Address: 280 East Losey St (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 343-2166 **Fax #** (309)343-3289

HFS ID Number:

Date of Initial License for Current Owners: 01/01/196

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: A. Dean Shipman **Telephone Number:** (419) 254-7841
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 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 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	84	Skilled (SNF)	84	30,744	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	84	TOTALS	84	30,744	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	9,748	5,059	8,836	23,643	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,748	5,059	8,836	23,643	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.90%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/25/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 4,404

Medicare Intermediary CGS Administrators, LLC

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: 12/31

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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	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	241,680	17,217	17,567	276,464		276,464		276,464			1
2	Food Purchase		167,412		167,412		167,412	(1,000)	166,412			2
3	Housekeeping	162,813	22,511	497	185,821		185,821		185,821			3
4	Laundry	36,299	17,366		53,665		53,665		53,665			4
5	Heat and Other Utilities			105,662	105,662	1,509	107,171		107,171			5
6	Maintenance	59,455	19,347	89,767	168,569		168,569		168,569			6
7	Other (specify):* Security & Waste			8,299	8,299		8,299		8,299			7
8	TOTAL General Services	500,247	243,853	221,792	965,892	1,509	967,401	(1,000)	966,401			8
	B. Health Care and Programs											
9	Medical Director			19,790	19,790		19,790		19,790			9
10	Nursing and Medical Records	1,686,601	173,221	225,430	2,085,252	69	2,085,321		2,085,321			10
10a	Therapy	519,826	9,966	3,222	533,014		533,014		533,014			10a
11	Activities	53,445	2,437	2,660	58,542		58,542		58,542			11
12	Social Services	98,628	710	(837)	98,501		98,501		98,501			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Fit Tests			4,550	4,550		4,550		4,550			15
16	TOTAL Health Care and Programs	2,358,500	186,334	254,815	2,799,649	69	2,799,718		2,799,718			16
	C. General Administration											
17	Administrative	119,300		205,404	324,704	(36,693)	288,011		288,011			17
18	Directors Fees											18
19	Professional Services			55,307	55,307		55,307	(55,307)				19
20	Dues, Fees, Subscriptions & Promotions			68,199	68,199		68,199	(12,701)	55,498			20
21	Clerical & General Office Expenses	197,862	57,940	77,287	333,089		333,089	3,762	336,851			21
22	Employee Benefits & Payroll Taxes			588,273	588,273	26,101	614,374		614,374			22
23	Inservice Training & Education			2,509	2,509		2,509		2,509			23
24	Travel and Seminar			23,516	23,516		23,516		23,516			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,417	90,417		90,417		90,417			26
27	Other (specify):*											27
28	TOTAL General Administration	317,162	57,940	1,110,912	1,486,014	(10,592)	1,475,422	(64,246)	1,411,176			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,175,909	488,127	1,587,519	5,251,555	(9,014)	5,242,541	(65,246)	5,177,295			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 Galesburg #0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			96,134	96,134	10,726	106,860		106,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(810)	(810)	(1,712)	(2,522)		(2,522)			32
33	Real Estate Taxes			150,643	150,643		150,643		150,643			33
34	Rent-Facility & Grounds			462,271	462,271		462,271	(462,271)				34
35	Rent-Equipment & Vehicles			52,206	52,206		52,206		52,206			35
36	Other (specify):*											36
37	**TOTAL Ownership**			760,444	760,444	9,014	769,458	(462,271)	307,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,641		154,641		154,641		154,641			39
40	Barber and Beauty Shops			778	778		778		778			40
41	Coffee and Gift Shops	26,637			26,637		26,637		26,637			41
42	Provider Participation Fee			151,804	151,804		151,804		151,804			42
43	Other (specify):*		21,741	104,056	125,797		125,797		125,797			43
44	**TOTAL Special Cost Centers**	26,637	176,382	256,638	459,657		459,657		459,657			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,202,546	664,509	2,604,601	6,471,656		6,471,656	(527,517)	5,944,139			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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(1,000)	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	(509)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(177)	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	12,500	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(54,647)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(7,073)	21		24
25	Fund Raising, Advertising and Promotional	(12,701)	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	(463,910)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (527,517)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (527,517)		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 Galesburg

ID# 0049460

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income	(939)	21	3
4	Donations Revenue	(40)	21	4
5	Accouning/Collection Fees	(660)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(462,271)	34	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**	(463,910)		49

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL 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	$ 205,404	HCR Manor Care Services, LLC	0.00%	$ 205,404	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,202,547	Heartland Employment Services, LLC	0.00%	3,202,547		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,407,951			$ 3,407,951	$ *	14

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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								1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care at Arlington Heights	Arlington Heights				5
6			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				6
7			Manor Care of Hinsdale IL, LLC	Hinsdale				7
8			Manor Care of Homewood IL, LLC	Homewood				8
9			Manor Care of Libertyville IL, LLC	Libertyville				9
10			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				10
11			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				11
12			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				12
13			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				13
14			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Arden Courts of Geneva IL, LLC	Geneva				15
16			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				16
17			Arden Courts of Northbrook IL, LLC	Northbrook				17
18			Arden Courts of Palos Heights IL, LLC	Palos Heights				18
19			Arden Courts of South Holland IL, LLC	South Holland				19
20								20
21								21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Kathryn S. Hoops	BOD						25
26	Thomas Kile	BOD						26
27	Damian Rodgers	BOD						27
28	Andrea Sype	BOD						28
29	Rami Ubaydi	BOD						29
30								30

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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	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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 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 [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	2,636,740,077	485 NFs, HHs, &	$ 709,073	$ 0	5,611,500	$ 1,509	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	5,611,500	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,611,500	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	5,611,500	68	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	5,611,500	1	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,611,500	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	5,611,500	122,815	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	5,611,500	20,834	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	5,611,500	25,062	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	5,611,500	11,986	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	5,611,500	14,115	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	5,611,500	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	5,611,500	8,541	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	5,611,500	2,185	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,611,500	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		5,611,500	(1,666)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(46)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					$ 118,280,668	$ 37,116,512		$ 205,404	25

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										(1,712)	6
7	Interest Income / Interest Expense										(810)	7
8												8
9	TOTAL Facility Related						$	$			$ (2,522)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (2,522)	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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 141,174	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.)		$ 145,908	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,734	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 145,909	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.		$ 150,643	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	137,749	8
	2016	144,434	9
	2017	142,363	10
	2018	141,174	11
	2019	145,908	12

Lines 2 & 4: $145,908.26 = $72,954.13 for 1st half 2019 + $72,954.13 for 2nd half 2019

	FOR BHF USE ONLY		
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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049460

CONTACT PERSON REGARDING THIS REPORT A. Dean Shipman

TELEPHONE (419) 254-7841 FAX #: (800) 422-2089

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-10-427-018	See Attached	$ 145,908.26	$ 145,908.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 145,908.26	$ 145,908.26

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 of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,388 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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. [ ] (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	359,370	1986 & 2003	$ 121,935	1
2	Facility		2006	47,025	2
3	TOTALS	359,370		$ 168,960	3

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	69		1964	1964	$ 407,801	$ 35,390		$ 35,390	$	$ 969,940	4
5	7			2003	570,110						5
6	7/1/06 Capital Rate Adj #1			2003	81,936						6
7	8			2005	637,826						7
8	7/1/06 Capital Rate Adj #14			2005	125,742						8
	Improvement Type**										
9	Current Year Depreciation					29,572		29,572		2,392,036	9
10	Building Improvements			1968	73						10
11	Building Improvements			1969	1,059						11
12	Building Improvements			1970	1,083						12
13	Building Improvements			1971	10,602						13
14	Building Improvements			1972	5,946						14
15	Building Improvements			1973	758						15
16	Building Improvements			1974	817						16
17	Building Improvements			1975	3,645						17
18	Building Improvements			1978	19,333						18
19	Building Improvements			1983	1,350						19
20	Building Improvements			1984	21,913						20
21	Building Improvements			1985	50,936						21
22	Building Improvements			1986	25,696						22
23	Building Improvements			1987	19,172						23
24	Building Improvements			1988	15,735						24
25	Building Improvements			1989	36,615						25
26	Building Improvements			1990	29,293						26
27	Building Improvements			1991	9,501						27
28	Building Improvements			1992	24,536						28
29	Building Improvements			1993	16,600						29
30	Building Improvements			1994	4,373						30
31	Building Improvements			1995	15,312						31
32	Building Improvements			1996	254,337						32
33	Building Improvements			1997	621,302						33
34	Building Improvements			1998	43,001						34
35	Building Improvements			1999	94,276						35
36	Building Improvements			2000	69,994						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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Building Improvements	2001	$ 103,588	$		$	$	$	37
38	Building Improvements	2002	50,236						38
39	Building Improvements	2003	120,638						39
40	Building Improvements	2004	132,991						40
41	Building Improvements	2005	182,008						41
42									42
43	CORNER GUARDS	2006	225						43
44	FIRE PROTECTION PIPING	2006	600						44
45	BASIC ELECTRICAL	2006	490						45
46	WALLCOVERINGS	2006	1,215						46
47	7/1/19 Cap Audit Adj -Cost less than min for Cap	2006	(1,215)						47
48	3 SETS OF DOORS	2006	4,226						48
49	INSTALL GUTTERS/WINDOWS	2006	14,500						49
50	VINYL WALL COVERING	2006	150						50
51	7/1/19 Cap Audit Adj -Cost less than min for Cap	2006	(150)						51
52	GUTTERS	2006	2,025						52
53	7/1/19 Cap Audit Adj -Cost less than min for Cap	2006	(2,025)						53
54	FLOORING-KITCHEN STORAGE	2006	6,278						54
55	EXPAND FREEZER & COOLER	2006	30,957						55
56	DOOR	2006	3,041						56
57	SIDEWALKS	2007	6,879						57
58	SIDEWALKS	2007	2,106						58
59	boiler room door	2007	2,419						59
60	7/1/19 Cap Audit Adj -Cost less than min for Cap	2007	(2,419)						60
61	Fire Sprinkler System	2007	2,728						61
62	Architecture for Concrete	2007	1,739						62
63	LAUNDRY RM IMP-DRYWALL, PAINT & DOORS	2007	11,516						63
64	DOOR LEADING TO KITCHEN	2007	2,127						64
65	7/1/19 Cap Audit Adj -Cost less than min for Cap	2007	(2,127)						65
66	0707 NURSE STATION GEN'L OH	2007	631						66
67	0707 NURSE STATION CARPENTRY	2007	16,655						67
68	0707 NURSE STATION CABINETS	2007	12,567						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,925,272	$ 64,962		$ 64,962	$	$ 3,361,976	70

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,925,272	$ 64,962		$ 64,962	$	$ 3,361,976	1
2	HOT WATER HEATER	2008	11,677						2
3	7/1/19 Cap Audit Adj -this 2008 water heater replaced 2013	2008	(11,677)						3
4	new garage	2008	10,325						4
5	PT DOUBLE DOORS	2008	4,750						5
6	OT DOUBLE DOORS	2008	4,750						6
7	NEW GARAGE	2008	10,325						7
8	garage work	2008	1,950						8
9	Door Replacement / Renovation	2008	2,157						9
10	7/1/19 Cap Audit Adj -Cost less than min for Cap	2008	(2,157)						10
11	Concrete Ramp	2008	10,800						11
12	HVAC Controls	2009	2,540						12
13	7/1/19 Cap Audit Adj -overhead & interest non-allowable	2009	(2,540)						13
14	HVAC Controls	2008	39,798						14
15									15
16	40685 Kithen door	2010	2,470						16
17	7/1/19 Cap Audit Adj -Cost less than min for Cap	2010	(2,470)						17
18	40686 & 88 front enterance awning	2010	6,396						18
19	40689-90 VCT flooring	2010	27,850						19
20	40701 Water Heater	2011	13,500						20
21	7/1/19 Cap Audit Adj -this 2011 water heater replaced 2016	2011	(13,500)						21
22	40702 acoustical ceiling	2011	7,200						22
23	40703 STAINLESS STEEL BACKSLACH	2011	7,650						23
24	40704 CEILING GRID IN DINING RM	2011	3,285						24
25	40712 WALL COVERING & CARPET in Front Corridor	2012	23,428						25
26	40720 BURNER ASSEMBLY FOR BOILER	2012	8,515						26
27	40721 WALLCOVERING in Front Corridor	2012	934						27
28	40722 FIRE DOOR In TV Lounge	2012	3,105						28
29	40723 WALLCOVERING in Front Corridor	2012	848						29
30	40724 WALL COVERING & CARPET-Front Corridor	2012	2,604						30
31	40725 WALLCOVERING IN FRONT CORRIDOR	2012	3,713						31
32	40726 WALLCOVERING IN FRONT CORRIDOR	2012	609						32
33	40730 CONCRETE Front Bldg & SEAL COAT Parking Lot	2012	6,388						33
34	TOTAL (lines 1 thru 33)		$ 4,110,495	$ 64,962		$ 64,962	$	$ 3,361,976	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		$ 4,110,495	$ 64,962		$ 64,962	$	$ 3,361,976	1
2	40738 Install WATER HEATER/rep HEAT Exchanger in boiler	2013	23,852						2
3	40747 LIGHTING UPGRADES	2014	7,027						3
4	40761 Shower stall repairs-installed new tile	2014	2,650						4
5	40762 Shower stall repairs-install flooring	2014	2,565						5
6									6
7	40766 Drain replaced, add flr sink in Kitchen Dishwash area	2015	6,638						7
8	40768 Floor replacement Kitchen Dishwash area	2015	6,165						8
9	40771 & 40776 Boiler - replace flue,burners, & controls	2015	14,967						9
10	40774 Repair Ktchen Wall - Studs, Durock, Paint	2015	2,565						10
11	40779 Install Firestop materials to 1st flr. smoke barriers	2015	14,874						11
12	40782 HM Doors (2) at SW exit & small dining rom	2015	3,149						12
13	Conduit & Wiring for Generator Life Safey Branch	2016	9,375						13
14	Fire Alarm System	2016	17,033						14
15	Sewer repair under concrete floor & flooring for dietary kitchen	2016	9,529						15
16	Roofing repairs to valley & flashing - installed ice guard	2016	4,997						16
17	Repair water damage Ceiling in employee break room	2016	4,114						17
18	Roof repair over cooler/freezer, east side of bldg	2016	4,822						18
19	Furnish & install Water Heater BTH-400 in mechanical room	2016	21,069						19
20									20
21	Chiller Compressor - AC unit A1 entire bldg outside Mech Rm	2017	7,500						21
22	Asphalt /striping- parking lot	2017	2,850						22
23	Tile walls in resident baths -rms 143, 145, 147	2017	2,625						23
24	Sidewalk- E side of bldg	2017	9,350						24
25									25
26	Pump for boiler in Mech Rm	2018	9,853						26
27	**Heat Pump-Boiler REFUND**	2018	(9,853)						27
28	**Boiler, 1Million BTU Patterson Kelly-Boiler Rm**	2019	22,975						28
29	**Water Softener,Boiler Rm**	2019	5,194						29
30	**Boiler, Patterson-Kelley Velox Model N1000VX-Boiler Rm**	2019	23,500						30
31	**Water Heater, 300-400 BTH-Mech Rm**	2019	16,269						31
32	**BLOWER, AIR SPA 120V**	2019	2,502						32
33	**Flue System bor Boiler-mech room**	2019	2,787						33
34	**TOTAL (lines 1 thru 33)**		$ 4,361,438	$ 64,962		$ 64,962	$	$ 3,361,976	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,361,438	$ 64,962		$ 64,962	$	$ 3,361,976	1
2	Secure Care Door Alams - Kitchen Storage Rm	2020	5,483						2
3	Boiler Line - Room 111	2020	2,654						3
4	Mixing Valve in Boiler Rm	2020	5,681						4
5	Access Panels (4) - sprinkler system Rms 121, 123, 125 & 127	2020	3,650						5
6	Shut Off Valve on Boiler -Boiler Rm	2020	3,264						6
7	Air Compressor/Magnetic Line Starter -Sprinkler System Back M	2020	3,372						7
8	Valve/Piping -Sprinkler System	2020	6,710						8
9	Annunciator Panel -Front Nurse Station	2020	3,135						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	TOTAL (lines 1 thru 33)		$ 4,395,387	$ 64,962		$ 64,962	$	$ 3,361,976	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 1,911,096	$ 31,172	$ 31,172	$		$ 1,862,856	71
72	Current Year Purchases	51,729						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			10,726	10,726			74
75	TOTALS	$ 1,962,825	$ 31,172	$ 41,898	$ 10,726		$ 1,862,856	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)	$ 6,527,172	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,134	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,860	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,726	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,224,832	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	CIP	$	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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 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:	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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 34,675 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	2013 Ford E350 Turtle	$	$ 17,531	17
18		Top Odyssey			18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		$	$ 17,531	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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1918 hrs	$ 83,626	7	$ 422	$ 2,056	1,925	$ 86,104	1
2	Licensed Speech and Language Development Therapist	10a	90 hrs	3,944			620	90	4,564	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1960 hrs	85,450			7,290	1,960	92,740	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				154,641		154,641	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3			36	2,324		36	2,324	12
13	Other (specify): X-Ray & Lab | IV	43, 2 & 3				104,056	21,741		125,797	13
14	TOTAL			$ 173,020	43	$ 106,802	$ 186,348	4,011	$ 466,170	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 Galesburg # 0049460 Report Period Beginning: 01/01/2020 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 694	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (60,712))	(2,194)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,500)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,960		13
14	Buildings, at Historical Cost	6,161,387		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	196,825		16
17	Accumulated Depreciation (book methods)	(5,224,832)		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 (spe OMIT	106,214		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,408,554	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,407,054	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 190,348	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	211,503		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,551		31
32	Accrued Real Estate Taxes(Sch.IX-B)	145,908		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	151,511		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 720,821	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 720,821	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 686,233	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,407,054	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,330,171	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,330,171	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	508,338	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)**	$ 508,338	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(1,152,276)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,152,276)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 686,233	24 *

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,390,717	1
2	Discounts and Allowances for all Levels	(2,195,280)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,195,437	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,645,249	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,645,249	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	939	12
13	Barber and Beauty Care	839	13
14	Non-Patient Meals	1,000	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	341,800	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,438	19
20	Radiology and X-Ray	40,919	20
21	Other Medical Services	63,823	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 534,758	23
	D. Non-Operating Revenue		
24	Contributions	40	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purch Disc| QI pymts| Gov Sub Inc	604,510	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 604,510	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,979,994	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	965,892	31
32	Health Care	2,799,649	32
33	General Administration	1,486,014	33
	B. Capital Expense		
34	Ownership	760,444	34
	C. Ancillary Expense		
35	Special Cost Centers	307,853	35
36	Provider Participation Fee	151,804	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,471,656	40
41	**Income before Income Taxes (line 30 minus line 40)****	508,338	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 508,338	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,606,171	44
45	Private Pay - Net Inpatient Revenue	1,049,745	45
46	Medicare - Net Inpatient Revenue	918,803	46
47	Other-(specify) Hospice	163,968	47
48	Other-(specify) Insurance	456,750	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,195,437	49

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

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

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

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,991	2,141	$ 88,410	$ 41.29	1
2	Assistant Director of Nursing	3,638	3,911	128,162	32.77	2
3	Registered Nurses	12,731	13,686	397,646	29.05	3
4	Licensed Practical Nurses	15,718	16,897	393,111	23.27	4
5	CNAs & Orderlies	42,218	45,527	631,648	13.87	5
6	CNA Trainees	447	516	6,234	12.08	6
7	Licensed Therapist	6,612	7,082	308,812	43.61	7
8	Rehab/Therapy Aides	6,579	7,046	211,014	29.95	8
9	Activity Director	2,847	3,059	53,445	17.47	9
10	Activity Assistants					10
11	Social Service Workers	3,900	4,205	98,628	23.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,204	19,589	241,680	12.34	15
16	Dishwashers					16
17	Maintenance Workers	2,327	2,492	59,455	23.86	17
18	Housekeepers	12,260	13,185	162,813	12.35	18
19	Laundry	3,104	3,335	36,299	10.88	19
20	Administrator	2,080	2,080	119,299	57.36	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,377	8,126	197,863	24.35	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	2,567	2,750	41,390	15.05	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,913	2,050	26,637	12.99	33
34	TOTAL (lines 1 - 33)	146,513	157,677	$ 3,202,546 *	$ 20.31	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	19,790	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)		$ 19,790		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,225	$ 74,753	10, 3	50
51	Licensed Practical Nurses	903	40,649	10, 3	51
52	Certified Nurse Assistants/Aides	1,916	62,185	10, 3	52
53	TOTAL (lines 50 - 52)	4,044	$ 177,587		53

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shaila Hart	Administrator	0	$ 119,300
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,300

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 205,404
TOTAL (agree to Schedule V, line 17, col. 3)	$ 205,404
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 54,647
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	660
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)		$ 55,307

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,391
Unemployment Compensation Insurance	21,676
FICA Taxes	226,712
Employee Health Insurance	252,545
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	18,911
Appreciation, Oth Benefits & Mktg Adj	(1,695)
Tuition Program	4,200
SMSP Match	
Employee Uniforms	5,533
Home Office Allocation	26,101
TOTAL (agree to Schedule V, line 22, col.8)	$ 614,374

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	32,850
Health Care Worker Background Check	
(Indicate # of checks performed 268)	5,466
Patient Background Checks 415	4,150
Dues & Subscriptions	5,109
Association Dues	6,586
Advertising	10,274
Other Licenses and Permits	1,774
Less: Non-Allowable Association Dues	(2,427)
Less: Public Relations Expense	( )
Non-allowable advertising	(10,274)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,498

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	23,516
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)	$ 23,516

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2020 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. **IHCA $3,022 & AHCA $1,137**

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,211** 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. **7/28/18**

(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. $ **151,804**
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. $ **1,000**

(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?
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 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.