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: 0049452

Facility Name: Heartland of Henry

Address: 1650 Indian Town Rd (Number) Henry (City) 61537 (Zip Code)

County: Marshall

Telephone Number: (309) 364-3905 **Fax #** (309) 364-3119

HFS ID Number:

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

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 Henry # 0049452 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	94	Skilled (SNF)	94	34,404	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	94	TOTALS	94	34,404	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	8,275	8,663	4,701	21,639	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,275	8,663	4,701	21,639	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.90%

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 04/01/1989

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 62 and days of care provided 2,401

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 Henry # 0049452 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	233,718	10,651	9,999	254,368		254,368		254,368			1
2	Food Purchase		159,527		159,527		159,527	(569)	158,958			2
3	Housekeeping	96,499	16,674	280	113,453		113,453		113,453			3
4	Laundry	28,711	6,885		35,596		35,596		35,596			4
5	Heat and Other Utilities			84,810	84,810	1,464	86,274		86,274			5
6	Maintenance	62,193	16,069	48,422	126,684		126,684		126,684			6
7	Other (specify):* Security & Waste			4,478	4,478		4,478		4,478			7
8	TOTAL General Services	421,121	209,806	147,989	778,916	1,464	780,380	(569)	779,811			8
	B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600			9
10	Nursing and Medical Records	1,742,957	119,123	26,557	1,888,637	67	1,888,704		1,888,704			10
10a	Therapy	484,924	4,256	290	489,470		489,470		489,470			10a
11	Activities	71,571	398	135	72,104		72,104		72,104			11
12	Social Services	93,100	1,096	535	94,731		94,731		94,731			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Fit Tests			4,770	4,770		4,770		4,770			15
16	TOTAL Health Care and Programs	2,392,552	124,873	34,887	2,552,312	67	2,552,379		2,552,379			16
	C. General Administration											
17	Administrative	164,812		199,251	364,063	(35,626)	328,437		328,437			17
18	Directors Fees											18
19	Professional Services			14,983	14,983		14,983	(14,983)				19
20	Dues, Fees, Subscriptions & Promotions			39,503	39,503		39,503	(10,199)	29,304			20
21	Clerical & General Office Expenses	203,745	40,297	89,142	333,184		333,184	(35,673)	297,511			21
22	Employee Benefits & Payroll Taxes			589,371	589,371	25,313	614,684		614,684			22
23	Inservice Training & Education			1,378	1,378		1,378		1,378			23
24	Travel and Seminar			1,699	1,699		1,699		1,699			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,224	16,224		16,224		16,224			26
27	Other (specify):*							(70)	(70)			27
28	TOTAL General Administration	368,557	40,297	951,551	1,360,405	(10,313)	1,350,092	(60,925)	1,289,167			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,182,230	374,976	1,134,427	4,691,633	(8,782)	4,682,851	(61,494)	4,621,357			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 Henry #0049452 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			140,539	140,539	10,402	150,941		150,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(117)	(117)	(1,620)	(1,737)		(1,737)			32
33	Real Estate Taxes			116,135	116,135		116,135		116,135			33
34	Rent-Facility & Grounds			462,271	462,271		462,271	(462,271)				34
35	Rent-Equipment & Vehicles			28,508	28,508		28,508		28,508			35
36	Other (specify):*											36
37	**TOTAL Ownership**			747,336	747,336	8,782	756,118	(462,271)	293,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,336		78,336		78,336		78,336			39
40	Barber and Beauty Shops			3,956	3,956		3,956		3,956			40
41	Coffee and Gift Shops	33,157			33,157		33,157		33,157			41
42	Provider Participation Fee			168,367	168,367		168,367		168,367			42
43	Other (specify):* IV | X-Ray & Lab		20,825	50,014	70,839		70,839		70,839			43
44	**TOTAL Special Cost Centers**	33,157	99,161	222,337	354,655		354,655		354,655			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,215,387	474,137	2,104,100	5,793,624		5,793,624	(523,765)	5,269,859			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 Henry # 0049452 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 Reference	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	(569)	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	(123)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(316)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(70)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,461)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(34,881)	21		24
25	Fund Raising, Advertising and Promotional	(10,199)	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	(472,146)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (523,765)		$	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))**	$ (523,765)		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 Henry

ID# 0049452

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	(353)	21	3
4	Donations Revenue		21	4
5	Accouning/Collection Fees	(9,522)	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**	(472,146)		49

Facility Name & ID Number Heartland of Henry # 0049452 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	$ 199,251	HCR Manor Care Services, LLC	0.00%	$ 199,251	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,215,388	Heartland Employment Services, LLC	0.00%	3,215,388		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			$ 3,414,639			$ 3,414,639	$ *	14

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

Facility Name & ID Number Heartland of Henry # 0049452 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 Galesburg IL, LLC	Galesburg				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 Henry # 0049452 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 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	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 Henry # 0049452 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	5,442,291	$ 1,464	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	5,442,291	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,442,291	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	5,442,291	66	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	5,442,291	1	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,442,291	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	5,442,291	119,112	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	5,442,291	20,206	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	5,442,291	24,307	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	5,442,291	11,624	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	5,442,291	13,689	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	5,442,291	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	5,442,291	8,283	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	5,442,291	2,119	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,442,291	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		5,442,291	(1,616)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(4)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					$ 118,280,668	$ 37,116,512		$ 199,251	25

Facility Name & ID Number Heartland of Henry # 0049452 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										(1,620)	6
7	Interest Income / Interest Expense										(117)	7
8												8
9	TOTAL Facility Related						$	$			$ (1,737)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (1,737)	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 Henry # 0049452 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.**	$ 115,666	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.)		$ 115,900	2
3. Under or (over) accrual (line 2 minus line 1).		$ 234	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 115,901	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.		$ 116,135	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	128,207	8
	2016	125,304	9
	2017	118,421	10
	2018	115,666	11
	2019	115,901	12

Lines 2 & 4: $115,900.60 = $57,950.30 for 1st half 2019 - $57,950.30 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 Henry COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0049452

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.	03-09-326-001	See Attached	$ 115,900.60	$ 115,900.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 115,900.60	$ 115,900.60

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 Henry # 0049452 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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		1,075,062		$ 174,000	1
2					2
3	TOTALS	1,075,062		$ 174,000	3

Facility Name & ID Number Heartland of Henry # 0049452 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	93		1988	1988	$ 1,748,953	$ 53,364		$ 53,364	$	$ 1,589,948	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					54,806		54,806		2,052,954	9
10	Land/Bldg. Improvement			1988	325,853						10
11	Land/Bldg. Improvement			1989	2,438						11
12	Land/Bldg. Improvement			1990	242						12
13	Land/Bldg. Improvement			1991	9,067						13
14	Land/Bldg. Improvement			1992	8,628						14
15	Land/Bldg. Improvement			1993	19,910						15
16	Land/Bldg. Improvement			1994	3,550						16
17	Land/Bldg. Improvement			1995	7,068						17
18	Land/Bldg. Improvement			1996	23,631						18
19	Land/Bldg. Improvement			1997	40,560						19
20	Land/Bldg. Improvement			1998	294,168						20
21	Land/Bldg. Improvement			1999	62,274						21
22	Land/Bldg. Improvement			2000	31,516						22
23	Land/Bldg. Improvement			2001	84,131						23
24	Land/Bldg. Improvement			2002	31,713						24
25	Land/Bldg. Improvement			2003	159,405						25
26	Land/Bldg. Improvement			2004	44,107						26
27	Land/Bldg. Improvement			2005	237,319						27
28	Land/Bldg. Improvement			2006	60,860						28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Henry # 0049452 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	0607 RES RM RENOV - LIGHT FIXTURES	2007	$ 2,539	$		$	$	$	37
38	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						38
39	0607 RES RM RENOV - TOILET	2007	6,660						39
40	0607 RES RM RENOV - WALL HEATER	2007	6,000						40
41	0607 RES RM RENOV - PAINTING	2007	3,261						41
42	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						42
43	0607 RES RM RENOV - WALL CABINETS	2007	3,000						43
44	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						44
45	2 concrete sidewalks	2008	2,600						45
46	CARPENTRY	2008	500						46
47	0907 EMERGENCY LIGHTING	2007	6,357						47
48	07/01/2019 audit adjustment L22-Ovhd & Int	2007	(1,126)						48
49	0907 EMERGENCY LIGHTING	2007	38,409						49
50	0907 EMERGENCY LIGHTING	2008	6,454						50
51	07/01/2019 audit adjustment L24-Ovhd & Int	2008	(6,454)						51
52	0907 EMERGENCY LIGHTING	2008	4,450						52
53	AC CONDENSING UNIT	2008	4,287						53
54	ELECTRICAL FOR TVS	2008	10,260						54
55	SERVICE DOOR ENTRANCE1	2008	5,365						55
56	FIRE RATED SHUTTER	2008	4,806						56
57	DOOR FOR ENTRANCE	2008	5,365						57
58	Entrance Doors	2008	1,000						58
59	BI 022449 0309 FLOORING REPLACEMENT	2010	25,203						59
60	LI 022448 back door concrete pad	2010	4,246						60
61	LI 022459 5' wide sidewalk, therapy	2010	4,038						61
62	LI 022460 Seal & strip pkg lot	2010	4,978						62
63	BI 022463 Radiant Heat Panels	2011	7,450						63
64	BI 022469 135 Sprinkler Heads	2011	10,215						64
65	BI 022481 PT reno-prime/paint ceilings, vwc removal	2011	41,370						65
66	BI 022482 0211 PARKING LOT	2011	83,215						66
67	07/01/2019 audit adjustment L24-Ovhd & Int	2011	(345)						67
68	BI 022484 Wallcovering	2011	19,675						68
69	07/01/2019 audit adjustment L24-missing inv	2011	(241)						69
70	TOTAL (lines 4 thru 69)		$ 3,903,946	$ 108,170		$ 108,170	$	$ 3,642,902	70

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

Facility Name & ID Number Heartland of Henry # 0049452 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		$ 3,903,946	$ 108,170		$ 108,170	$	$ 3,642,902	1
2	000000022490 GAS WATER HEATER	2012	5,395						2
3	000000022496 0212 Nurse Call System	2012	1,353						3
4	000000022497 0112 Fire Alarm System	2012	38,093						4
5	07/01/2019 audit adjustment L24-Ovhd & Int	2012	(234)						5
6	000000022498 0112 Fire Alarm System	2012	1,184						6
7	000000022499 ADJ ASSET #22497-fire alarm system	2012	2,898						7
8	000000022500 ADJ ASSET #22497-fire alarm system	2012	6,762						8
9									9
10	22508 Freight for flooring	2013	1,338						10
11	22510 FLOORING - tile for bath/res rm	2013	10,173						11
12	22511 22 RES RM BATH FLOORING	2013	18,357						12
13	22513 22 RESIDENT ROOM FLOORING	2013	6,054						13
14	22517 Water Heater 100, 300 Theray, + Laundry	2013	6,200						14
15	22520 A#22511 RES RM BATH FLOORING	2013	12,188						15
16									16
17	400 Hall Res. Rms - Resilient Flooring	2014	15,520						17
18	400 Hall Res. Rms - Carpeting & Pads	2014	1,399						18
19	400 Hall Res. Rms - Paint & Wall Covering	2014	43,416						19
20	003-14MW 400 Hall Res. Rms - Light Fixtures	2014	11,863						20
21	Pipes for Sprinklers - Wings 100, 200 & 400 (1of3)	2015	3,106						21
22	Pipes for Sprinklers - Wings 100, 200 & 400 (2of3)	2015	8,339						22
23	Water Heater BTR-200 for Kithchen	2015	5,931						23
24	400 Hall Res Rms - Crash Rails, Drywall Repair & Paint	2014	6,165						24
25	400 Hall Drapes/Shades/Blinds	2014	3,791						25
26	Generator Panel & Wiring	2015	5,760						26
27	Pipes for Sprinklers - Wings 100, 200 & 400 (3of3)	2015	13,169						27
28	Damper Motor - Kitchen/Mechanical Room	2015	1,027						28
29	HVAC Compressor for unit RT-9702 Model 17358	2015	1,530						29
30	Electrical Wiring for Computers	2015	10,890						30
31	07/01/2019 audit adjustment L24-Missing Inv	2015	(275)						31
32	Sprinkler Heads (58) & Dry Pendent Heads (9)	2015	5,022						32
33	Vinyl Fence	2015	2,935						33
34	TOTAL (lines 1 thru 33)		$ 4,153,295	$ 108,170		$ 108,170	$	$ 3,642,902	34

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

Facility Name & ID Number Heartland of Henry # 0049452 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**		$ 4,153,295	$ 108,170		$ 108,170	$	$ 3,642,902	1
2	LED Light Fixtures for parking lot	2015	4,694						2
3									3
4	Replace 4 Centrifugal Downblast Roof Exhaust Fans	2016	4,500						4
5	Water Heater in 400 Hall, AO Smith 80 gallon	2016	3,833						5
6	Repair Drywall then Paint Walls, Floors, & Ceiling in Laundry Room	2016	11,200						6
7	Replace Drywall, Fire Tape/caulk, & Paint Ceilings in Hallways	2016	18,200						7
8									8
9	AHU 10T HVAC System placed above business office	2017	17,000						9
10	Emerg Fire rated Doors & exit devices-Employee ent ext & int, outpt t	2017	23,864						10
11	**07/01/2019 audit adjustment L24-duplicate Inv**	2017	(1,285)						11
12	Secure care exit unit w/keypads in south wing outside exit	2017	9,525						12
13	Metal door 400 hall	2017	5,609						13
14	Hot water heater off dining room	2017	7,260						14
15									15
16	Drywall -200 Hall Large Dining room (2)	2018	9,860						16
17	Ceiling in PT	2018	3,000						17
18	Add'l -Drywall -200 Hall Large Dining room (2)	2018	3,288						18
19	Pass Thru Window -Kitchen	2018	6,500						19
20	Ceiling & Paint - Kitchen	2018	6,500						20
21	Add'l -Ceiling in PT	2018	2,500						21
22	Add'l -Ceiling in PT	2018	3,150						22
23	Ceiling & Paint - Dining Room	2018	6,500						23
24	Add'l -Ceiling & Paint - Dining Room	2018	5,767						24
25	Exit Doors HM - halls 100, 300, & 400 (3)	2018	5,000						25
26	Drywall and paint -Arcardia Lounge	2018	2,950						26
27	part of A# 22694	2018							27
28	**Duct Insulation in Attic**	2018	3,912						28
29	**Add'l -Duct Insulation in Attic**	2018	3,912						29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 4,320,534	$ 108,170		$ 108,170	$	$ 3,642,902	34

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

Facility Name & ID Number Heartland of Henry # 0049452 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		$ 4,320,534	$ 108,170		$ 108,170	$	$ 3,642,902	1
2	Concrete-Front Sidewalks 50ft	2019	2,500						2
3	Fence-Arcadia ctyd -PVC 6 ft tall 114 linear ft w gate	2019	9,500						3
4	Concrete-Front Sidewalks 50ft Additional	2019	6,689						4
5	Panic Device-Arcadia ctyd outside Gate	2019	2,757						5
6	Parking lot (entire) sealing/striping	2019	11,168						6
7	Exit Doors- 100,300, & 400 halls	2019	6,500						7
8	Secure Care Panels-Kitchen Delivery / 400 Hall doors	2019	3,422						8
9	Painting -Men's restrm & 200 Hall Linens	2019	2,500						9
10	Exit Doors- 100,300, & 400 halls Additional	2019	6,938						10
11	Painting -Men's restrm & 200 Hall Linens Additional	2019	4,980						11
12	Painting -Nurses station area	2019	8,000						12
13	Painting -Nurses station area Additional	2019	8,000						13
14	Compressor -Sprinker Systems	2019	2,940						14
15	Painting -Nurses station area Additional	2019	3,000						15
16	Backflow Preventor - Sprinkler Systems	2019	11,890						16
17	Painting -Nurses station area Additional	2019	25,000						17
18	Sprinkler Heads (13)-Laundry & Mech rms	2019	2,510						18
19									19
20	Vinyl wallcovering -below handrail Lobby, Svc Hall @ dining room, & nurse station		3,219						20
21	Vinyl wallcovering -below handrail Lobby, Svc Hall @ dining room, & nurse station		4,315						21
22	Piping/fittings -Dry Sprinkler System		4,835						22
23	FIRE DAMPERS -thru out facility within HVAC ducts.		3,595						23
24	Secure Care system @ Arcadia Courtyard Gate		2,733						24
25	Renov -Bldg Exterior (fascia/siding/soffit) & Staining		6,141						25
26	Renov -Bldg Exterior (fascia/siding/soffit) & Staining		6,141						26
27	Renov -Bldg Exterior (fascia/siding/soffit) & Staining		6,141						27
28	Renov -Bldg Exterior (fascia/siding/soffit) & Staining		8,473						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,484,421	$ 108,170		$ 108,170	$	$ 3,642,902	34

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

Facility Name & ID Number Heartland of Henry # 0049452 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	$ 2,052,638	$ 32,369	$ 32,369	$		$ 1,966,486	71
72	Current Year Purchases	4,342						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			10,402	10,402			74
75	TOTALS	$ 2,056,980	$ 32,369	$ 42,771	$ 10,402		$ 1,966,486	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)	$ 6,715,401	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 140,539	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,941	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,402	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,609,388	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	$ 16,660	92
93			93
94			94
95		$ 16,660	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 Henry # 0049452 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: $ #REF! 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 Transports	2013 Dodge Grand Carava	$	$ 3,307	17
18		2017 T-150 Transit Van		6,953	18
19				above amount includes	19
20				gas & maintenance too	20
21	TOTAL		$	$ 10,260	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 Henry # 0049452 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	1378 hrs	$ 67,383		$	$ 943	1,378	$ 68,326	1
2	Licensed Speech and Language Development Therapist	10a	1042 hrs	50,970			247	1,042	51,217	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1911 hrs	93,472			3,066	1,911	96,538	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				78,336		78,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3			3	165		3	165	12
13	Other (specify): X-Ray & Lab | IV	43, 2 & 3				50,014	20,825		70,839	13
14	TOTAL			$ 211,825	3	$ 50,179	$ 103,417	4,334	$ 365,421	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 Henry # 0049452 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	$ (3,596)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (112,611))	(165,037)		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)**	$ (168,633)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	4,484,421		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,056,980		16
17	Accumulated Depreciation (book methods)	(5,609,388)		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	103,195		22
23	Other(specify): CIP	16,660		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,225,868	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,057,235	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 105,689	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,298		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,454		31
32	Accrued Real Estate Taxes(Sch.IX-B)	115,901		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	65,150		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 569,492	$	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)**	$ 569,492	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 487,743	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,057,235	$	48

*(See instructions.)

Facility Name & ID Number Heartland of Henry # 0049452 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**	$ 1,288,733	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,288,733	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,062	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)**	$ 110,062	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(911,052)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (911,052)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 487,743	24 *

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

Facility Name & ID Number Heartland of Henry # 0049452 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	$ 5,352,774	1
2	Discounts and Allowances for all Levels	(1,428,338)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,924,436	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,201,189	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,201,189	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	423	12
13	Barber and Beauty Care	4,834	13
14	Non-Patient Meals	569	14
15	Telephone, Television and Radio	3,000	15
16	Rental of Facility Space		16
17	Sale of Drugs	173,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,263	19
20	Radiology and X-Ray	4,704	20
21	Other Medical Services	17,915	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 247,757	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purch Disc| QI pymts| Gov Sub Inc	530,304	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 530,304	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,903,686	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	778,916	31
32	Health Care	2,552,312	32
33	General Administration	1,360,405	33
	B. Capital Expense		
34	Ownership	747,336	34
	C. Ancillary Expense		
35	Special Cost Centers	186,288	35
36	Provider Participation Fee	168,367	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,793,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	110,062	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 110,062	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,352,178	44
45	Private Pay - Net Inpatient Revenue	1,932,732	45
46	Medicare - Net Inpatient Revenue	333,185	46
47	Other-(specify) Hospice	87,393	47
48	Other-(specify) Insurance	218,948	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,924,436	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 Henry # 0049452 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	1,898	2,085	$ 106,616	$ 51.13	1
2	Assistant Director of Nursing	1,452	1,595	59,824	37.51	2
3	Registered Nurses	15,714	17,262	502,837	29.13	3
4	Licensed Practical Nurses	13,945	15,318	368,688	24.07	4
5	CNAs & Orderlies	43,165	47,469	670,239	14.12	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	6,743	7,418	362,833	48.91	7
8	Rehab/Therapy Aides	3,611	3,972	122,091	30.74	8
9	Activity Director	4,451	4,873	71,571	14.69	9
10	Activity Assistants					10
11	Social Service Workers	3,582	3,943	93,100	23.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,709	18,356	233,718	12.73	15
16	Dishwashers					16
17	Maintenance Workers	2,128	2,320	62,193	26.81	17
18	Housekeepers	7,196	7,945	96,499	12.15	18
19	Laundry	2,462	2,692	28,711	10.67	19
20	Administrator	2,080	2,080	164,811	79.24	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,444	8,667	203,747	23.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,560	1,707	34,753	20.36	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,301	1,419	33,157	23.37	33
34	TOTAL (lines 1 - 33)	135,441	149,121	$ 3,215,387 *	$ 21.56	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	2,600	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 2,600		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Legner	Administrator	0	$ 164,812
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 164,812

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 199,251
TOTAL (agree to Schedule V, line 17, col. 3)	$ 199,251
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 5,461
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	9,522
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)		$ 14,983

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,096
Unemployment Compensation Insurance	2,454
FICA Taxes	220,215
Employee Health Insurance	293,893
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	27,519
Appreciation, Oth Bene, LT Incent & Mktg Adj	(457)
Tuition Program	
SMSP Match	
Employee Uniforms	4,651
Home Office Allocation	25,313
TOTAL (agree to Schedule V, line 22, col.8)	$ 614,684

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	12,901
Health Care Worker Background Check	
(Indicate # of checks performed 91)	1,587
Patient Background Checks 173	1,730
Dues & Subscriptions	7,386
Association Dues	7,370
Advertising	7,483
Other Licenses and Permits	1,046
Less: Non-Allowable Association Dues	(2,716)
Less: Public Relations Expense	( )
Non-allowable advertising	(7,483)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,304

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,699
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)	$ 1,699

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Henry # 0049452 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 $3,382 & AHCA $1,272**

(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. $ **26,039** 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. $ **168,367**
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. $ **569**

(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.