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: 0049585

Facility Name: Heartland of Macomb

Address: 8 Doctor Lane (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: (309) 833-5555 **Fax #** (208) 833-3749

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

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 # ( )

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

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 Macomb # 0049585 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	80	Skilled (SNF)	80	29,280	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	80	TOTALS	80	29,280	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	8,680	2,825	5,158	16,663	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,680	2,825	5,158	16,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.91%

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 80 and days of care provided 3,871

Medicare Intermediary CGS Administrators

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 Macomb # 0049585 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	201,402	19,512	13,336	234,250		234,250		234,250			1
2	Food Purchase		140,718		140,718		140,718	(11,232)	129,486			2
3	Housekeeping	100,035	11,256	150	111,441		111,441		111,441			3
4	Laundry	8,596	10,194		18,790		18,790		18,790			4
5	Heat and Other Utilities			80,499	80,499	1,414	81,913		81,913			5
6	Maintenance	44,246	11,026	59,274	114,546		114,546		114,546			6
7	Other (specify):* Security & Waste			9,694	9,694		9,694		9,694			7
8	TOTAL General Services	354,279	192,706	162,953	709,938	1,414	711,352	(11,232)	700,120			8
	B. Health Care and Programs											
9	Medical Director			8,670	8,670		8,670		8,670			9
10	Nursing and Medical Records	1,364,992	118,352	40,831	1,524,175	65	1,524,240		1,524,240			10
10a	Therapy	458,129	3,331	38,633	500,093		500,093		500,093			10a
11	Activities	42,755	196	2,704	45,655		45,655		45,655			11
12	Social Services	90,014	489	1,809	92,312		92,312		92,312			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Fit Tests			2,600	2,600		2,600		2,600			15
16	TOTAL Health Care and Programs	1,955,890	122,368	95,247	2,173,505	65	2,173,570		2,173,570			16
	C. General Administration											
17	Administrative	107,592		192,549	300,141	(34,408)	265,733		265,733			17
18	Directors Fees											18
19	Professional Services			66,026	66,026		66,026	(66,026)				19
20	Dues, Fees, Subscriptions & Promotions			69,700	69,700		69,700	(17,711)	51,989			20
21	Clerical & General Office Expenses	182,247	45,929	225,455	453,631		453,631	(174,589)	279,042			21
22	Employee Benefits & Payroll Taxes			680,856	680,856	24,465	705,321		705,321			22
23	Inservice Training & Education			1,346	1,346		1,346		1,346			23
24	Travel and Seminar			7,594	7,594		7,594		7,594			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,648	93,648		93,648		93,648			26
27	Other (specify):*											27
28	TOTAL General Administration	289,839	45,929	1,337,174	1,672,942	(9,943)	1,662,999	(258,326)	1,404,673			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,600,008	361,003	1,595,374	4,556,385	(8,464)	4,547,921	(269,558)	4,278,363			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 Macomb #0049585 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			157,359	157,359	10,054	167,413		167,413			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(2,975)	(2,975)	(1,590)	(4,565)		(4,565)			32
33	Real Estate Taxes			68,973	68,973		68,973		68,973			33
34	Rent-Facility & Grounds			470,241	470,241		470,241	(470,241)				34
35	Rent-Equipment & Vehicles			64,357	64,357		64,357		64,357			35
36	Other (specify):*											36
37	**TOTAL Ownership**			757,955	757,955	8,464	766,419	(470,241)	296,178			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,437		96,437		96,437		96,437			39
40	Barber and Beauty Shops			554	554		554		554			40
41	Coffee and Gift Shops	23,084			23,084		23,084		23,084			41
42	Provider Participation Fee			121,108	121,108		121,108		121,108			42
43	Other (specify):* IV | X-Ray & Lab		9,700	119,353	129,053		129,053		129,053			43
44	**TOTAL Special Cost Centers**	23,084	106,137	241,015	370,236		370,236		370,236			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,623,092	467,140	2,594,344	5,684,576		5,684,576	(739,799)	4,944,777			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 Macomb # 0049585 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	(11,232)	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	(464)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(118)	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		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(61,917)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(172,734)	21		24
25	Fund Raising, Advertising and Promotional	(17,711)	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	(475,623)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (739,799)		$	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))**	$ (739,799)		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 Macomb

ID# 0049585

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		21	3
4	Donations Revenue	(1,273)	21	4
5	Accouning/Collection Fees	(4,109)	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	(470,241)	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**	(475,623)		49

Facility Name & ID Number Heartland of Macomb # 0049585 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	$ 192,549	HCR Manor Care Services, LLC	0.00%	$ 192,549	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	2,623,093	Heartland Employment Services, LLC	0.00%	2,623,093		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			$ 2,815,642			$ 2,815,642	$ *	14

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

Facility Name & ID Number Heartland of Macomb # 0049585 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			Heartland of Galesburg IL, LLC	Galesburg				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		REMEMBER TO DELETE THE FACILTY YOU ARE WORKING ON AND THIS COMMENT!						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 Macomb # 0049585 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 Macomb # 0049585 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	5,259,876	$ 1,414	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	5,259,876	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,259,876	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	5,259,876	64	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	5,259,876	1	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,259,876	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	5,259,876	115,120	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	5,259,876	19,529	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	5,259,876	23,492	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	5,259,876	11,235	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	5,259,876	13,230	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	5,259,876	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	5,259,876	8,006	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	5,259,876	2,048	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	5,259,876	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		5,259,876	(1,562)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(28)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					$ 118,280,668	$ 37,116,512		$ 192,549	25

Facility Name & ID Number Heartland of Macomb # 0049585 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										(1,590)	6
7	Interest Income / Interest Expense										(2,975)	7
8												8
9	TOTAL Facility Related						$	$			$ (4,565)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (4,565)	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 Macomb # 0049585 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.**	$ 63,262	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.)		$ 66,118	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,856	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,117	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.		$ 68,973	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	60,336	8
	2016	59,902	9
	2017	61,712	10
	2018	63,262	11
	2019	66,117	12

Lines 2 & 4: $66,117.34 = $33,058.67 for 1st half 2019 + $33,058.67 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 Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0049585

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.	11-300-953-00	See Attached	$ 64,766.92	$ 64,766.92
2.	11-300-961-00	See Attached	$ 1,350.42	$ 1,350.42
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,117.34	$ 66,117.34

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 Macomb # 0049585 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,624 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 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		66,924	1983	$ 57,104	1
2		66,924	2003	49,141	2
3	TOTALS	133,848		$ 106,245	3

Facility Name & ID Number Heartland of Macomb # 0049585 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	58			1983	$ 824,586	$ 28,317		$ 28,317	$	$ 1,321,250	4
5	6			2001	404,817						5
6	Audit adj 7/1/03(#1)			2001	(55,875)						6
7	16			2003	726,962						7
8	Audit adj 7/1/06 (#17)			2003	56,765						8
	Improvement Type**										
9	Current Year Depreciation					77,627		77,627		2,308,670	9
10	Building Improvements			1983	19,035						10
11	Building Improvements			1983	300						11
12	Building Improvements			1984	15,076						12
13	Building Improvements			1985	20,813						13
14	Building Improvements			1986	46,524						14
15	Building Improvements			1987	70,097						15
16	Building Improvements			1988	2,068						16
17	Building Improvements			1989	26,929						17
18	Building Improvements			1990	12,332						18
19	Building Improvements			1991	5,547						19
20	Building Improvements			1992	10,800						20
21	Building Improvements			1993	37,102						21
22	Building Improvements			1994	51,433						22
23	Building Improvements			1995	126,184						23
24	Building Improvements			1996	56,792						24
25	Building Improvements			1997	144,096						25
26	Building Improvements			1998	386,332						26
27	Building Improvements			1999	156,620						27
28	Building Improvements			2000	40,061						28
29	Building Improvements			2001	37,893						29
30	Building Improvements			2002	102,949						30
31	Building Improvements			2003	151,347						31
32	Building Improvements			2004	49,783						32
33	Building Improvements			2005	39,206						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 Macomb # 0049585 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	Physical Therapy Addn - LI - Soil Testing	2006	$ 3,773	$		$	$	$	37
38	Physical Therapy Addn - LI - Landscaping	2006	24,893						38
39	7/1/19 Cap Audit Adj -Included in contractor total	2006	(24,893)						39
40	Physical Therapy Addn - LI - Permit Fees	2006	5,423						40
41	Physical Therapy Addn - BI - Genl Contracting	2006	428,270						41
42	7/1/19 Cap Audit Adj -difference btwn filed and contractor stmt	2006	24,693						42
43	Physical Therapy Addn - BI - Carpeting	2006	6,948						43
44	Physical Therapy Addn - BI - Electrical	2006	288						44
45	Physical Therapy Addn - BI - Arch & Eng	2006	51,475						45
46	Physical Therapy Addn - BI - Genl A/H	2006	17,950						46
47	Corr & Main Dining Room - BI - Genl O/H	2006	7,409						47
48	7/1/19 Cap Audit Adj -non-allowable related party overhead	2006	(7,409)						48
49	Corr & Main Dining Room - BI - Carpentry	2006	26,688						49
50	Corr & Main Dining Room - BI - Wallcovering	2006	36,561						50
51	HR Office, BB Shop Renovation - BI - Carpet, Wallcovering	2007	6,145						51
52	Fire Safety Caulking	2007	24,060						52
53	Siding and Soffits on Gar	2007	5,100						53
54	Fire Walls and Caulking	2007	24,060						54
55	Cabinets in Beauty Shop	2007	2,982						55
56	FIRE WALLS AND CHALKING	2007	(24,060)						56
57	RENOVATE BREAKROOM - PLUMBING	2008	1,174						57
58	RENOVATE BREAKROOM - CABINETRY	2008	2,321						58
59	RENOVATE BREAKROOM - CEILING	2008	853						59
60	RENOVATE BREAKROOM - PAINTING	2008	704						60
61	RENOVATE BREAKROOM - VINYL TILE FLOORING (VCT)	2008	1,323						61
62	PAINTING CLOSETS	2008	9,850						62
63	ADJ PAINTING CLOSETS	2008	4,174						63
64	Water Heater	2009	16,031						64
65	7/1/19 Cap Audit Adj -this 2006 water heater repl in 2014		(16,031)						65
66	Water Heater	2009	1,781						66
67	7/1/19 Cap Audit Adj -asset less than minimum for capitalizatio	2009	(1,781)						67
68	BI 010345 plumbing for asset 10342-dishwasher	2010	19,574						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,246,903	$ 105,944		$ 105,944	$	$ 3,629,920	70

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

Facility Name & ID Number Heartland of Macomb # 0049585 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		$ 4,246,903	$ 105,944		$ 105,944	$	$ 3,629,920	1
2	10354 Water Lines	2010	8,600						2
3	10355 roof duct	2011	14,367						3
4	10356 Add'l cost roof duct	2011	8,499						4
5	10371 HEAT EXCHANGER	2011	3,835						5
6	10372 Add'l cost roof duct	2011	2,520						6
7	10374 VWC, BASE, & CHAIR RAILS	2011	5,550						7
8	10375 VWC & ORDER, PAINT	2011	5,277						8
9	10397 STORAGE SHED	2012	4,500						9
10	10403 ICE MACH IN MAIN DINING ROOM	2013	8,600						10
11	7/1/19 Cap Audit Adj -reclass to moveable equipmt	2013	(8,600)						11
12	10404 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						12
13	7/1/19 Cap Audit Adj -asset less than minimum for capitalizatio	2013	(1,975)						13
14	10405 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						14
15	10409 SEWER LINE REPLACEMENT	2013	123,120						15
16	10412 0513 Roof Replacement-Main Bldg	2013	195,307						16
17	10414 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						17
18	10415 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						18
19	7/1/19 Cap Audit Adj -asset less than minimum for capitalizatio	2013	(1,975)						19
20	10421 80 GAL HOT WATER HEATER replaced	2014	16,110						20
21	10429 PAVING-asphalt patching	2014	12,004						21
22									22
23	10430 Boiler Heat Exchanger & Burner replaced	2015	20,205						23
24	10435 Breaker Panel, 100 amp, in boiler room	2015	8,550						24
25	10439 Parking Lot Striping & Sealing	2015	10,790						25
26									26
27	Replaced power supply & interface for fire alarm sys	2016	6,084						27
28	Installed Mixing Valve	2016	2,875						28
29	Install Door & frame - Rear Exit Door	2016	5,000						29
30	Install Door & Frame - Exterior Door by DON office	2016	5,300						30
31	Install Door & Frame - Maintenance Exterior door	2016	5,248						31
32	Install water heater	2016	18,250						32
33	Replace concrete ramp-side of building 30' x 7'	2016	4,630						33
34	TOTAL (lines 1 thru 33)		$ 4,744,024	$ 105,944		$ 105,944	$	$ 3,629,920	34

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

Facility Name & ID Number Heartland of Macomb # 0049585 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		$ 4,744,024	$ 105,944		$ 105,944	$	$ 3,629,920	1
2	Ceramic tile installation in 400 shower room repair	2017	2,950						2
3	Install down LED light fixture on pole-exterior	2017	4,002						3
4	Install double wall flue pipe in mech room to water heaters	2017	8,545						4
5	Install motor & pump assembly for heating system	2017	3,700						5
6									6
7	1 WATER VALVE replaced and hooked up bypass	2018	5,225						7
8	Rooftop Unit AC BOARD replaced	2018	3,297						8
9	RTU COMPRESSOR replacement	2018	4,525						9
10	2 Ton RTU & supply duct to Administrator's office	2018	7,873						10
11	Corridor lighting in all main hallways	2018	7,938						11
12	10522 Economizer, Air Dampers, Exhaust -RTUs #1-7	2019	22,019						12
13	10533 Sprinkler Inspection	2019	2,960						13
14	10537 RTU- 5T Carrier	2019	7,900						14
15									15
16	Compressor for 3 door cooler in kitchen	2019	2,246						16
17	7/1/19 Cap Audit Adj -asset less than minimum for capitalizatio	2019	(2,246)						17
18									18
19	10558 Firestop Systems thru out bldg.	2020	10,800						19
20	10560 Paint/vinyl flr/ - Employee Restroom	2020	3,500						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)		$ 4,839,258	$ 105,944		$ 105,944	$	$ 3,629,920	34

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

Facility Name & ID Number Heartland of Macomb # 0049585 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	$ 1,618,585	$ 51,415	$ 51,415	$		$ 1,551,133	71
72	Current Year Purchases	19,185						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			10,054	10,054			74
75	TOTALS	$ 1,637,770	$ 51,415	$ 61,469	$ 10,054		$ 1,551,133	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)	$ 6,583,273	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 157,359	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,413	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,054	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,181,053	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 Macomb # 0049585 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: $ 35,433 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	2017 T-150 transit van	$	$ 9,859	17
18	Patient Transportation	2018 T-150 transit van		19,064	18
19				above figures include	19
20				gas & maintenance	20
21	TOTAL		$	$ 28,924	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 Macomb # 0049585 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	1321 hrs	$ 60,286	634	$ 39,824	$ 353	1,955	$ 100,463	1
2	Licensed Speech and Language Development Therapist	10a	1422 hrs	64,925			967	1,422	65,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	74 hrs	3,370			2,011	74	5,381	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				96,437		96,437	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3			1	9		1	9	12
13	Other (specify): X-Ray & Lab | IV	43, 2 & 3				119,353	9,700		129,053	13
14	TOTAL			$ 128,581	635	$ 159,186	$ 109,468	3,452	$ 397,235	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 Macomb # 0049585 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	$ 300	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (240,633))	100,370		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)**	$ 100,670	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	4,830,658		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,646,370		16
17	Accumulated Depreciation (book methods)	(5,181,053)		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	102,541		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,504,761	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,605,431	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,143	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,344		30
31	Accrued Taxes Payable (excluding real estate taxes)	91,430		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,117		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	166,516		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 593,550	$	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)**	$ 593,550	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,011,881	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,605,431	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Macomb # 0049585 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**	$ 1,799,851	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,799,851	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(298,278)	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)**	$ (298,278)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(489,692)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (489,692)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,011,881	24 *

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

Facility Name & ID Number Heartland of Macomb # 0049585 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	$ 4,771,889	1
2	Discounts and Allowances for all Levels	(1,893,533)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,878,356	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,489,453	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,489,453	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	591	13
14	Non-Patient Meals	11,232	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	191,607	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,163	19
20	Radiology and X-Ray	19,274	20
21	Other Medical Services	54,919	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 323,786	23
	D. Non-Operating Revenue		
24	Contributions	1,273	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,273	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purch Disc| QI pymts| Gov Sub Inc	693,430	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 693,430	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,386,298	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	709,938	31
32	Health Care	2,173,505	32
33	General Administration	1,672,942	33
	B. Capital Expense		
34	Ownership	757,955	34
	C. Ancillary Expense		
35	Special Cost Centers	249,128	35
36	Provider Participation Fee	121,108	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,684,576	40
41	**Income before Income Taxes (line 30 minus line 40)****	(298,278)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (298,278)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,445,159	44
45	Private Pay - Net Inpatient Revenue	623,094	45
46	Medicare - Net Inpatient Revenue	709,540	46
47	Other-(specify) Hospice	43,639	47
48	Other-(specify) Insurance	56,924	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,878,356	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 Macomb # 0049585 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	2,152	2,327	$ 89,558	$ 38.49	1
2	Assistant Director of Nursing	2,160	2,335	75,273	32.24	2
3	Registered Nurses	15,057	16,277	460,577	28.30	3
4	Licensed Practical Nurses	8,528	9,219	206,630	22.41	4
5	CNAs & Orderlies	31,728	34,299	512,408	14.94	5
6	CNA Trainees	69	79	1,251	15.84	6
7	Licensed Therapist	5,202	5,650	257,937	45.65	7
8	Rehab/Therapy Aides	5,968	6,482	200,192	30.88	8
9	Activity Director	2,830	3,043	42,755	14.05	9
10	Activity Assistants					10
11	Social Service Workers	3,098	3,351	90,014	26.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,033	15,169	201,402	13.28	15
16	Dishwashers					16
17	Maintenance Workers	1,914	2,052	44,246	21.56	17
18	Housekeepers	7,650	8,256	100,035	12.12	18
19	Laundry	780	829	8,596	10.37	19
20	Administrator	2,080	2,080	107,592	51.73	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,271	8,080	182,247	22.56	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	1,071	1,163	19,295	16.59	31
32	Other Health Care(specify)					32
33	Other(specify)	2,024	2,183	23,084	10.57	33
34	TOTAL (lines 1 - 33)	113,615	122,874	$ 2,623,092 *	$ 21.35	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	8,670	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)		$ 8,670		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	(225)	$ (13,472)	10, 3	50
51	Licensed Practical Nurses	110	4,940	10, 3	51
52	Certified Nurse Assistants/Aides	1,079	33,458	10, 3	52
53	TOTAL (lines 50 - 52)	964	$ 24,926		53

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Athena Brooks	Administrator	0	$ 107,592
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,592

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 192,549
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 192,549

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 61,917
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	4,109
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)		$ 66,026

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,047
Unemployment Compensation Insurance	91,430
FICA Taxes	183,312
Employee Health Insurance	294,846
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	10,775
Appreciation, Oth Benefits & Mktg Adj	2,235
Tuition Program	
SMSP Match	
Employee Uniforms	5,211
Home Office Allocation	24,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 705,321

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	$ 3,980
Advertising: Employee Recruitment	23,125
Health Care Worker Background Check	
(Indicate # of checks performed 117)	3,724
Patient Background Checks 44	440
Dues & Subscriptions	10,759
Association Dues	6,272
Advertising	18,816
Other Licenses and Permits	2,584
Non-Allowable Association Dues	1,105
Less: Public Relations Expense	( )
Non-allowable advertising	(18,816)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,989

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,594
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)	$ 7,594

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Macomb # 0049585 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 $5,360 & AHCA $2,017**

(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. $ **19,560** 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. $ **121,108**
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. $ **11,232**

(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.