

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0049403

Facility Name: Heartland of Moline

Address: 833 Sixteenth Ave Moline 61265
Number City Zip Code

County: Rock Island

Telephone Number: 309-764-6744 Fax # 309-764-8176

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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 Moline

0049403 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>149</u>	Skilled (SNF)	<u>149</u>	<u>54,534</u>	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	<u>149</u>	TOTALS	<u>149</u>	<u>54,534</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,394</u>	<u>15,149</u>	<u>18,561</u>	<u>38,104</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,394</u>	<u>15,149</u>	<u>18,561</u>	<u>38,104</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.87%

D. How many bed-hold days during this year were paid by the Department?
_____ (Do not include bed-hold 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 ☒

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

I. On what date did you start providing long term care at this location?
Date started 01/01/83

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/07/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 149 and days of care provided 12,478

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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 Moline # 0049403 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	306,111	18,535	21,381	346,027		346,027		346,027			1
2	Food Purchase		303,140		303,140		303,140	(1,282)	301,858			2
3	Housekeeping	204,629	19,916	722	225,267		225,267		225,267			3
4	Laundry	46,517	15,606		62,123		62,123		62,123			4
5	Heat and Other Utilities			173,358	173,358	2,096	175,454		175,454			5
6	Maintenance	50,065	20,327	74,679	145,071		145,071		145,071			6
7	Other (specify):* Med Waste			1,561	1,561		1,561		1,561			7
8	TOTAL General Services	607,322	377,524	271,701	1,256,547	2,096	1,258,643	(1,282)	1,257,361			8
	B. Health Care and Programs											
9	Medical Director			12,679	12,679		12,679		12,679			9
10	Nursing and Medical Records	2,830,840	178,826	54,843	3,064,509	51	3,064,560		3,064,560			10
10a	Therapy	1,367,643	11,149	42,566	1,421,358		1,421,358		1,421,358			10a
11	Activities	92,176	1,327	1,585	95,088		95,088		95,088			11
12	Social Services	167,861		1,765	169,626		169,626		169,626			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,458,520	191,302	113,438	4,763,260	51	4,763,311		4,763,311			16
	C. General Administration											
17	Administrative	123,242		650,408	773,650	(338,885)	434,765		434,765			17
18	Directors Fees											18
19	Professional Services			40,936	40,936		40,936	(40,936)				19
20	Dues, Fees, Subscriptions & Promotions			60,783	60,783		60,783	(27,802)	32,981			20
21	Clerical & General Office Expenses	410,798	43,901	224,120	678,819		678,819	(162,036)	516,783			21
22	Employee Benefits & Payroll Taxes			888,688	888,688	41,800	930,488		930,488			22
23	Inservice Training & Education			1,424	1,424		1,424		1,424			23
24	Travel and Seminar			8,741	8,741		8,741		8,741			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			215,763	215,763		215,763		215,763			26
27	Other (specify):*							(439)	(439)			27
28	TOTAL General Administration	534,040	43,901	2,090,863	2,668,804	(297,085)	2,371,719	(231,213)	2,140,506			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,599,882	612,727	2,476,002	8,688,611	(294,938)	8,393,673	(232,495)	8,161,178			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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			554,683	554,683	16,072	570,755		570,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,880,713	2,880,713	278,866	3,159,579	(2,880,932)	278,647			32
33	Real Estate Taxes			130,622	130,622		130,622		130,622			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,733	35,733		35,733		35,733			35
36	Other (specify):*											36
37	TOTAL Ownership			3,601,751	3,601,751	294,938	3,896,689	(2,880,932)	1,015,757			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		514,928		514,928		514,928		514,928			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	31,089			31,089		31,089		31,089			41
42	Provider Participation Fee			239,385	239,385		239,385		239,385			42
43	Other (specify):* IV X-Ray & Lab		50,438	69,778	120,216		120,216		120,216			43
44	TOTAL Special Cost Centers	31,089	565,366	309,163	905,618		905,618		905,618			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,630,971	1,178,093	6,386,916	13,195,980		13,195,980	(3,113,427)	10,082,553			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,282)	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	(82)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(597)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(439)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,924)	21		18
19	Entertainment				19
20	Contributions	(3,130)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,721)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(140,209)	21		24
25	Fund Raising, Advertising and Promotional	(27,802)	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 Page 5a	(2,890,241)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,113,427)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,113,427)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(826)	21	3
4	Donations Revenue	(268)	21	4
5	Accounting/Collection Fees	(8,215)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(2,880,932)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,890,241)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Moline # 0049403 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,282)	0	0	0	0	0	0	0	0	0	0	(1,282)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,282)	0	0	0	0	0	0	0	0	0	0	(1,282)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,936)	0	0	0	0	0	0	0	0	0	0	(40,936)	19
20	Fees, Subscriptions & Promotions	(27,802)	0	0	0	0	0	0	0	0	0	0	(27,802)	20
21	Clerical & General Office Expenses	(162,036)	0	0	0	0	0	0	0	0	0	0	(162,036)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(439)	0	0	0	0	0	0	0	0	0	0	(439)	27
28	TOTAL General Administration	(231,213)	0	0	0	0	0	0	0	0	0	0	(231,213)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(232,495)	0	0	0	0	0	0	0	0	0	0	(232,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Moline # 0049403 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,880,932)	0	0	0	0	0	0	0	0	0	0	(2,880,932)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,880,932)	0	0	0	0	0	0	0	0	0	0	(2,880,932)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,113,427)	0	0	0	0	0	0	0	0	0	0	(3,113,427)	45

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 Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				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.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 650,408	HCR Manor Care Services, LLC	100.00%	\$ 650,408	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,630,971	Heartland Employment Services, LLC	100.00%	5,630,971		4
5	V	10a	Therapy Management	16,371	Heartland Rehabilitation Services, LLC	100.00%	16,371		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			\$ 6,297,750			\$ 6,297,750	\$ *	14

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

Facility Name & ID Number

Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7								7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care of Hinsdale IL, LLC	Hinsdale				14
15			Manor Care of Homewood IL, LLC	Homewood				15
16			Manor Care of Libertyville IL, LLC	Libertyville				16
17			Manor Care of Naperville IL, LLC	Naperville				17
18			Manor Care of Northbrook IL, LLC	Northbrook				18
19			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				19
20			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				20
21			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				21
22			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				22
23			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				23
24			Manor Care of South Holland IL, LLC	South Holland				24
25			Manor Care of Westmont IL, LLC	Westmont				25
26			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				26
27			Arden Courts of Geneva IL, LLC	Geneva				27
28			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				28
29			Arden Courts of Northbrook IL, LLC	Northbrook				29
30			Arden Courts of Palos Heights IL, LLC	Palos Heights				30

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			Arden Courts of South Holland IL, LLC	South Holland				1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heartland of Moline # 0049403 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Moline# 0049403

Report Period Beginning:

01/01/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	\$ 619,847	\$	12,724,037	\$ 2,096	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs			12,724,037	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			12,724,037	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	14,966	9,743	12,724,037	51	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs			12,724,037	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			12,724,037	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	61,861,920	32,341,614	12,724,037	209,205	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	14,679,699	5,396,995	12,724,037	56,706	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	2,741,751		12,724,037	45,612	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	5,141,603		12,724,037	17,387	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	6,319,907		12,724,037	24,413	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs			12,724,037	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	3,929,156		12,724,037	13,288	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	720,726		12,724,037	2,784	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			12,724,037	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,762,500,577		30,527,148		12,724,037	103,237	22
23	32	Directly Assigned Interest	Not Allocated			18,393,998			175,629	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				31,980,611				24
25	TOTALS					\$ 176,931,332	\$ 37,748,352		\$ 650,408	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Conv. Sub. Debentures		X				\$ 2,372,944	\$ 2,224,525		0.0790	\$ 175,629	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										103,237	7	
8	Interest Expense / Interest Income										(219)	8	
9	TOTAL Facility Related						\$ 2,372,944	\$ 2,224,525			\$ 278,647	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,372,944	\$ 2,224,525			\$ 278,647	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	123,452	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.)				\$	127,037	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,585	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	127,037	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.				\$	130,622	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	124,756	8	FOR BHF USE ONLY	
		2012	122,892	9		
		2013	124,633	10		
		2014	123,452	11		
		2015	127,037	12		
Line 2: \$127,036.92 = \$63,518.46 for 1st half 2015 + \$63,518.46 for 2nd half 2015				13	FROM R. E. TAX STATEMENT FOR 2015	13
Line 4: Used same amounts as line 2				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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049403

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 1705109001	See Attached	\$ 125,780.84	\$ 125,780.84
2. 1705144004	See Attached	\$ 1,256.08	\$ 1,256.08
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 127,036.92	\$ 127,036.92

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

A. Square Feet: 50,742

B. General Construction Type: ExteriorMasonryFrameSteel, Fire resistantNumber of Stories1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983 & 2003	\$ 181,010	1
2			2006	48,251	2
3	TOTALS			\$ 229,261	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118		1996	1996	\$ 1,033,964	\$ 89,647		\$ 89,647		\$ 2,798,896	4
5				1993	56,519						5
6	11			1998	1,398,475						6
7	10 beds in 2001 & 10 beds in 2006			2001	821,410						7
8	Physical Therapy addition-general contractor			2010	267,733						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					288,270		288,270		4,622,136	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						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 Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Land Improvements	1995	\$ 980	\$		\$	\$	\$	37
38 Building Improvements	1995	32,598						38
39 Land Improvements: Sign, Landscaping, and Concrete Bumpers	1996	25,027						39
40 Building Improvements: Painting/Wallcovering, Carpet, Paging sy	1996	126,134						40
41 doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								41
42 hand rails,electrical wiring, ceramic tile, and bathroom sinks								42
43 Building Improvements: Fire alarm	1996	45,151						43
44 Building Improvements: Intercom system	1996	27,230						44
45 Building Improvements: Renovation of lobby, foyer, busines office	1996	94,414						45
46 architect and engineering fees, interior design costs, drywall and								46
47 corner guards, aluminum chips, electrical heating, air conditioning								47
48 fire stop installation and access doors, and storage fees								48
49 Building Improvements: Wallcovering	1996	118,024						49
50 Building Improvements: Sewer Runs	1997	10,708						50
51 Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						51
52 door frames, millwork, carpetry, caulking, ceilings plaster,								52
53 plumbing comosite, electrical composite, sinks, conduit wiring,								53
54 door closing devices, nurses call system								54
55 Building Improvements: 18 Bed Addition, wallcovering, conncrete	1997	334,930						55
56 doors wood, telephone system, fencing wire, electrical transformer,								56
57 HVAC, hollow metal doors, duct work								57
58 Building Improvements: Install HVAC, electrical composite	1997	291,760						58
59 Building Improvements: Roof Replacement	1997	49,483						59
60 Building Improvements: Door	1997	1,042						60
61 Building Improvements: Siding on new additon	1997	4,993						61
62 Building Improvement: VWC from Inventory	1997	1,464						62
63 Land Improvements: Sign	1997	593						63
64 Land Improvements: Landscaping	1997	801						64
65 Land Improvements: Fence	1997	5,422						65
66 Bldg. Improvements: Cupola	1998	5,440						66
67 Bldg. Improvements: HVAC	1998	23,069						67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,522,732	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	70

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,522,732	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	Bldg. Improvements: Roof	1998	8,203						2
3	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						3
4	Bldg. Improvements: Add't HVAC	1998	15,464						4
5	Bldg. Improvements: 8 Bed Addition	1998	88,423						5
6	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						6
7	Land Improvements: Grading	1998	1,779						7
8	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						8
9	Bldg. Improvements: Doors	1998	10,151						9
10	Asphalt Work	1999	14,164						10
11	Smoking Shelter	1999	5,254						11
12	Overhead from Const	1999	29,447						12
13	Concrete Pad for Smoking	1999	924						13
14	Exit Device	1999	474						14
15	Carpet	1999	994						15
16	Carpet	1999	553						16
17	Awning	1999	2,787						17
18	Building Decorations	1999	652						18
19	Retainage for Carpet	1999	73						19
20	Retainage Fee for Carpet	1999	59						20
21	Wallboard	1999	568						21
22	Wiring	1999	3,850						22
23	Wall, Drain Lines, Electrica	1999	15,776						23
24	Boiler Pump	2000	5,433						24
25	HVAC Upgrade	2000	1,600						25
26	Boiler room exhuast	2000	5,684						26
27	Phone line	2000	800						27
28	Phone line	2000	800						28
29	Ceramic tile	2000	511						29
30	Carpet	2000	841						30
31	Sinks & faucet	2000	1,055						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,809,232	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,809,232	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	Add'l cost sinks	2000	218						2
3	Add'l cost carpeting	2000	59						3
4	Add'l cost carpet	2000	94						4
5	Retainer on boiler room exhaust	2000	632						5
6	Replace door in laundry	2000	4,932						6
7	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						7
8	Bldg Imprv - Carpentry/Electrical	2001	60,645						8
9	Bldg Imprv - Wallcovering	2001	11,630						9
10	Land Imprv - Concrete work	2001	4,941						10
11	Land Imprv - Walkway & Canopy	2001	3,858						11
12	Wire Component Connection	2001	2,542						12
13	Wire Component Connection	2002	327						13
14	Wire Component Connection	2002	402						14
15	Building Addition - VWC - Corridor	2002	19,847						15
16	Paint, VWC - Corridor Renovation	2001	45,377						16
17	Corner Guards	2002	7,153						17
18	Mini-Edger	2002	729						18
19	Corner Guards - Asset adjustment	2002	(4,953)						19
20	Building Addition - Paving/Landscaping	2002	8,679						20
21	Building Addition - Paving/Landscaping	2002	8,397						21
22	Building Addition - Paving/Landscaping	2002	111,907						22
23	Paving	2002	5,025						23
24	2 Dell celeron	2002	1,687						24
25	Electrical Work Overhead & Interest	2003	55,146						25
26	Overhead & Interest	2003	8,734						26
27	General Construction	2003	5,540						27
28	Carpet and Flooring	2003	83,248						28
29	Floorcovering	2003	702						29
30	Floorcovering	2003	251						30
31	HVAC	2003	7,643						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,276,159	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 6,276,159	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2 HVAC Kitchen retainage	2003	5,627						2
3 Overhead & Interest	2003	8,231						3
4 Overhead & Interest	2003	(8,231)						4
5 Retro Cost Adjustment	2003	84,377						5
6 Retro Cost Adjustment	2003	48,938						6
7 Sealcoat & Restripe Pkg.	2004	(48,938)						7
8 Sealcoat & Restripe Pkg.	2004	2,602						8
9 VWC	2004	68						9
10 Flooring and Painting	2004	1,486						10
11 VWC & Painting	2004	1,278						11
12 Carpet	2004	472						12
13 Interest	2005	3,449						13
14 Interest	2005	(3,449)						14
15 General Overhead	2005	46,589						15
16 General Overhead	2005	(46,589)						16
17 Fire Sprinkler System	2005	142,143						17
18 EXHAUST SYSTEM	2005	7,150						18
19 condensing unit	2006	4,193						19
20 Addition - Soil Testing & Plan Reviews	2006	28,303						20
21 Addition - Site Clearing, Grading, Concrete, Treatment, & Prep	2006	25,048						21
22 Addition - Landscaping	2006	45,850						22
23 Addition - Asphalt Paving	2006	16,258						23
24 Addition - Concrete Paving & Cast Stone	2006	139,095						24
25 Addition - Sewar Replacement & Fees	2006	36,004						25
26 Addition - Permit Fees	2006	9,757						26
27 Addition - Pre Construction & Bldg. Excavation	2006	139,343						27
28 Addition - Site Utilities	2006	11,905						28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,977,118	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,977,118	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	Addition - General Conditions	2006	115,912						2
3	Addition - Carpentry-Subcontr.	2006	195,647						3
4	Addition - Roofing/Waterproofing	2006	4,393						4
5	Addition - HM Doors/Frames/Drywall/Studs	2006	9,905						5
6	Addition - Wood Doors	2006	24,735						6
7	Addition - Ceiling Tile & Flooring	2006	17,927						7
8	Addition - Carpet/Paint/WC/Corner Guards	2006	42,687						8
9	Addition - Fire Sprinkler Syster	2006	19,963						9
10	Addition - Plumbing	2006	59,204						10
11	Addition - Basic Electrical	2006	108,830						11
12	Addition - Archetectual & Engineering Cost	2006	128,176						12
13	Addition - General Overhead	2006	71,933						13
14	Addition - Builders Risk Insurance	2006	1,100						14
15	Addition - Gypsum Board System	2006	62,975						15
16	Addition - Masonry & Metals	2006	142,412						16
17	Addition - Demolition	2006	13,731						17
18	Renov - General Overhead	2007	13,148						18
19	Renov - Carpentry - Subcontractor	2007	46,583						19
20	Renov - Wallcovering	2007	106,341						20
21	Renov - Interest on Construction	2007	957						21
22	0807 STORMSEWERS COURTYRD	2008	3,309						22
23	Adj 2006 Asset Addition - Arch & Engineering Cost	2008	1,765						23
24	Adj 2006 Asset Addition - General Overhead	2008	150						24
25	Adj 2006 Asset Addition - Arch & Engineering Cost	2008	1,943						25
26	0807 STORMSEWERS COURTYRD	2008	67,397						26
27	CONCRETE SIDEWALK	2008	1,672						27
28									28
29	Alum siding	2008	4,500						29
30	Door entrance closers	2008	3,613						30
31	alum siding	2009	2,223						31
32	000000090694 Safety ren-ovhead	2009	3,035						32
33	000000090694 Safety ren-interest	2009	167						33
34	TOTAL (lines 1 thru 33)		\$ 8,253,451	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,253,451	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	000000090695 Safey ren-carpentry	2009	13,140						2
3	000000090695 Safey ren-hm doors & frames	2009	17,553						3
4	000000090695 Safey ren-sprinklers	2009	1,228						4
5	000000090699 Cor ren-Gen ovhd capit	2009	6,495						5
6	000000090699 Cor ren-interest on const	2009	378						6
7	000000090699 Cor ren-resilient flooring	2009	95,159						7
8	000000090699 Cor ren-carpeting & pads	2009	1,342						8
9	000000090699 Cor ren-wall covering	2009	11,954						9
10	000000090699 Cor ren-cornder guards	2009	103						10
11	000000090699 Cor ren-resilient flooring	2009	123,012						11
12	000000090699 Cor ren-carpeting & pads	2009	1,162						12
13	000000090699 Cor ren-wall covering	2009	8,830						13
14	000000090704 Hollow metal door	2009	2,445						14
15	000000090705 ADJ ASSET #90699	2009	2,803						15
16	000000090706 ADJ ASSET #90699	2009	448						16
17	000000090708 vwc and ceiling tiles in	2009	13,241						17
18	000000090692 CONCRETE SIDEWALK	2008	21,279						18
19	000000090697 Grading and sub-drain til	2009	21,391						19
20									20
21	BI 090713 ADj ASSET 90699-vwc & ceiling tiles	2010	13,241						21
22	BI 090716 MOLINE PT-Arch & Eng costs	2010	84,024						22
23	BI 090717 CLSE PROJ MLNE PT MOVE-gen o/h cap	2010	17,706						23
24	BI 090721 MOLINE PT-wall covering	2010	1,310						24
25	BI 090733 ADJ ASSET #90721-wall covering	2010	2,026						25
26	BI 090738 Vestibule, front entry, seating renovation	2010	8,037						26
27	BI 090743 adj asset 90738-vestibule renovation	2010	8,037						27
28	LI 090722 MOLINE PT-general contractor	2010	157,687						28
29	LI 090723 MOLINE PT-soil & concrete testing	2010	7,645						29
30	000000090801 LAUNDRY HVAC	2012	19,810						30
31									31
32	90806 0812 Code Compliance-roof gable & cupola	2012	31,307						32
33	90813 1012 install fire-rated frame and slab-med rec off	2013	29,853						33
34	TOTAL (lines 1 thru 33)		\$ 8,976,097	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,976,097	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	90820 Boiler Flue Pipe Replacement	2013	3,583						2
3	90832 PARKING LOT SEALCOATING	2013	3,285						3
4									4
5	90837 Freight for carpet tile (for resident rooms)	2014	1,013						5
6	Interior renovation, 79 resident rooms, 75 bathroom, corridor, bird lounge, Monticello dining room, Project # "012-13MW":								6
7	012-13MW HVAC, Carpentry, Doors, and Frames	2014	112,117						7
8	012-13MW Ceiling Tile, resilient flooring, interior light fixtures	2014	223,131						8
9	012-13MW Carpet, Paint, Wallcovering	2014	257,759						9
10	012-13MW Plumbing	2014	50,496						10
11	012-13MW Elctrical	2014	14,941						11
12	90848 Water Heater, Cyclone BTH 150, 96% Efficient	2014	8,563						12
13	90849 Generator Electrical for offices, nurses stations & med rooms	2014	10,000						13
14	90850 Generator Electrical for offices, nurses stations & med rooms	2014	10,350						14
15	90856 Roofing above back hall	2014	4,393						15
16	90861 Fire shutters 6 x 6	2014	3,830						16
17									17
18	000000090864 ROOF-provide & install new roof	2014	4,393						18
19	000000090876 ARCHITECT-fac basement	2015	5,292						19
20	000000090877 PAINT AND FLOOR-central shower	2015	17,649						20
21	000000090879 Water heater flue damper installed	2015	1,600						21
22	000000090883 STRUCTURE ARCHITECT-fac basement	2015	1,050						22
23	000000090886 ARCHITECT FEE-facility basement	2015	5,402						23
24	000000090887 WIRE CONDUIT-boiler room	2015	9,968						24
25	000000090888-Carpentry, drywall, paint, and acoustical ceiling	2015	80,786						25
26	systems work in basement office area and corridors								26
27	000000090891 CEILING TILE-central shower	2015	5,310						27
28	000000090893 replaced old temperature control	2015	2,613						28
29	Roof Replacement	2016	76,583						29
30	Rewire PTAC Units in the Arcadia wing, 12 rooms	2016	24,500						30
31	Hot water system Consulting Engineering Services	2016	7,000						31
32	Replace Mixing Valves (2) & Faucet Cartridges	2016	10,137						32
33	Replace Heating Coil in ceiling above station B nourishment room	2016	2,918						33
34	TOTAL (lines 1 thru 33)		\$ 9,934,759	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12G, Carried Forward		\$ 9,934,759	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	1
2	Door Holder/Closers for Activities, connect to fire alarm system	2016	3,176						2
3	Rebuild Mixing Valves (2)	2016	3,576						3
4	Fountation Sealing for basement stairwell corridor area and	2016	4,520						4
5	Install Drain tile to divert water away from basement corridor area								5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,946,031	\$ 377,917		\$ 377,917	\$	\$ 7,421,032	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$3,594,685	\$176,766	\$176,766	\$		\$3,090,561	71
72	Current Year Purchases	32,060						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			16,072	16,072			74
75	TOTALS	\$3,626,745	\$176,766	\$192,838	\$16,072		\$3,090,561	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	2	
	Reference	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)	\$13,802,037	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$554,683	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$570,755	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$16,072	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,511,593	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$26,333 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	2009 Ford E350 T-Top Od	\$	\$9,400	17
18					18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		\$	\$9,400	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.

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

☒ 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	6878	hrs	\$ 291,841		\$ 44	6,878	\$ 291,885	1	
2	Licensed Speech and Language Development Therapist	10a	2661	hrs	112,915		187	2,661	113,102	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	10a	6886	hrs	292,211		10,918	6,886	303,129	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			514,928		514,928	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10	
11	Academic Education			hrs						11	
12	Other (specify): IV Therapy	43, 2					50,438		50,438	12	
13	Other (specify): X-Ray & Lab	43, 3				69,778			69,778	13	
14	TOTAL				\$ 696,967		\$ 69,778	\$ 576,515	16,425	\$ 1,343,260	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,588	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 354,358)	1,293,660		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,316,248	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,261		13
14	Buildings, at Historical Cost	9,946,031		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,626,745		16
17	Accumulated Depreciation (book methods)	(10,511,593)		17
18	Deferred Charges	167,603		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): OMIT	102,071		22
23	Other(specify): CIP	43,415		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,603,533	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,919,781	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 230,565	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	473,814		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	127,037		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	110,570		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 941,986	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,224,525		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)	\$ 2,224,525	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,166,511	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,753,270	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,919,781	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 32,439,883	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,439,883	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	650,069	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)	\$ 650,069	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(31,336,682)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (31,336,682)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,753,270	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,216,153	1
2	Discounts and Allowances for all Levels	(7,278,291)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,937,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,363,924	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,363,924	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,265	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,282	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,054,965	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,266	19
20	Radiology and X-Ray	46,211	20
21	Other Medical Services	345,924	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,543,913	23
	D. Non-Operating Revenue		
24	Contributions	268	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 268	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discounts</u>	82	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 82	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,846,049	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,256,547	31
32	Health Care	4,763,260	32
33	General Administration	2,668,804	33
	B. Capital Expense		
34	Ownership	3,601,751	34
	C. Ancillary Expense		
35	Special Cost Centers	666,233	35
36	Provider Participation Fee	239,385	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,195,980	40
41	Income before Income Taxes (line 30 minus line 40)**	650,069	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 650,069	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 655,958	44
45	Private Pay - Net Inpatient Revenue	3,623,707	45
46	Medicare - Net Inpatient Revenue	1,969,226	46
47	Other-(specify) <u>Hospice</u>	80,162	47
48	Other-(specify) <u>Insurance</u>	608,809	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,937,862	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,830	2,023	\$ 89,399	\$ 44.19	1
2	Assistant Director of Nursing	5,344	5,908	168,168	28.46	2
3	Registered Nurses	20,751	22,941	591,221	25.77	3
4	Licensed Practical Nurses	28,291	31,277	643,600	20.58	4
5	CNAs & Orderlies	89,084	98,812	1,273,002	12.88	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	19,279	21,314	904,425	42.43	7
8	Rehab/Therapy Aides	16,527	18,272	463,218	25.35	8
9	Activity Director	6,534	7,233	92,176	12.74	9
10	Activity Assistants					10
11	Social Service Workers	6,973	7,715	167,861	21.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,613	26,138	306,111	11.71	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,082	50,065	24.05	17
18	Housekeepers	15,128	16,749	204,629	12.22	18
19	Laundry	3,704	4,100	46,517	11.35	19
20	Administrator	2,080	2,080	123,242	59.25	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,156	18,923	410,798	21.71	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	3,216	3,568	65,450	18.34	31
32	Other Health Care(specify)					32
33	Other(specify)Hospitality	2,042	2,261	31,089	13.75	33
34	TOTAL (lines 1 - 33)	263,432	291,396	\$ 5,630,971 *	\$ 19.32	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	12,679	9, 3	36
37	Medical Records Consultant	Monthly	2,080	10, 3	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)		\$ 14,759		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Vickie Toomsen	Administrator	0	\$ 123,242	Workers' Compensation Insurance	\$	85,201	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		70,011	Advertising: Employee Recruitment	16,245	
				FICA Taxes		404,397	Health Care Worker Background Check	7,010	
				Employee Health Insurance		308,626	(Indicate # of checks performed 284)		
				Employee Meals			Patient Background Checks	670	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	338	
				Disability Payments			Association Dues	9,342	
				401K		18,480	Advertising	24,596	
				Appreciation, Oth Benefits & Mktg Adj		(7,002)	Other Licenses and Permits	592	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Non-Allowable Association Dues	(3,206)	
							Less: Public Relations Expense	()	
							Non-allowable advertising	(24,596)	
							Yellow page advertising	()	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 32,981		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 650,408					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
SN Global	Legal Fees		\$ 32,721			\$	Out-of-State Travel	\$	
(Legal fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)									
Andich & Andich	Collection Services		6,374				In-State Travel	8,741	
Transworld Systems Inc	Collection Services		1,841				Includes travel expense to the Home Office in Toledo, OH for regional meetings		
(Collection costs were adjusted off via Page 5a, Line 5)									
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 8,741	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Heartland of Moline</u>	STATE OF ILLINOIS # <u>0049403</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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. ICHA \$3,949 & ACHA \$2,187

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
 What was the average life used for new equipment added during this period? 5-10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,908 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? YES
 If YES, give effective date of lease. 04/07/11

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 239,385
 This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,282

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? NO
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
 Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
 Attach invoices and a summary of services for all architect and appraisal fees