FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0002923

Facility Name: Heartland Manor Nursing Ctr

Address: 410 NW 3rd St Box 10 (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-4081 **Fax #** (217) 932-4922

HFS ID Number:

Date of Initial License for Current Owners: 12/18/64

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 7/1/2013 to 6/30/2014 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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 N/A

	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	81	Skilled (SNF)	81	29,565	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	81	TOTALS	81	29,565	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	1,629	4,667	2,478	8,774	8
9	SNF/PED					9
10	ICF	7,768	5,384		13,152	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,397	10,051	2,478	21,926	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.16%

D. How many bed-hold days during this year were paid by the Department?
None (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)
Meals on Wheels

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 12/16/64

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 35 and days of care provided 2,478

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/14 Fiscal Year: 6/30/14

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 9	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	249,764	21,657	5,523	276,944		276,944		276,944			1
2	Food Purchase		141,807		141,807		141,807	(25,274)	116,533			2
3	Housekeeping	65,186	18,047	100	83,333		83,333		83,333			3
4	Laundry	63,126	8,154	590	71,870		71,870		71,870			4
5	Heat and Other Utilities			79,894	79,894		79,894	(36)	79,858			5
6	Maintenance	55,652	8,260	44,168	108,080		108,080	213	108,293			9
7	Other (specify):* Trash/Waste Disposal			3,660	3,660		3,660		3,660			7
8	**TOTAL General Services**	433,728	197,925	133,935	765,588		765,588	(25,097)	740,491			8
	B. Health Care and Programs											
9	Medical Director			9,263	9,263		9,263		9,263			9
10	Nursing and Medical Records	1,309,382	102,680	4,927	1,416,989		1,416,989		1,416,989			10
10a	Therapy											10a
11	Activities	54,681	3,989	1,794	60,464		60,464		60,464			11
12	Social Services	50,126		1,794	51,920		51,920		51,920			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,414,189	106,669	17,778	1,538,636		1,538,636		1,538,636			19
	C. General Administration											
17	Administrative	57,715			57,715		57,715		57,715			17
18	Directors Fees											18
19	Professional Services			103,173	103,173		103,173	(55)	103,118			19
20	Dues, Fees, Subscriptions & Promotions			19,181	19,181		19,181	(1,716)	17,465			20
21	Clerical & General Office Expenses	87,337	12,887	28,607	128,831		128,831	(5,813)	123,018			21
22	Employee Benefits & Payroll Taxes			369,921	369,921		369,921	6,248	376,169			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,883	3,883		3,883		3,883			24
25	Other Admin. Staff Transportation			2,530	2,530		2,530		2,530			25
26	Insurance-Prop.Liab.Malpractice			54,912	54,912		54,912		54,912			29
27	Other (specify):*											27
28	**TOTAL General Administration**	145,052	12,887	582,207	740,146		740,146	(1,336)	738,810			28
29	**TOTAL Operating Expense (sum of lines 8, 19 & 28)**	1,992,969	317,481	733,920	3,044,370		3,044,370	(26,433)	3,017,937			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 Manor Nursing Ctr #0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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							
	D. Ownership	1	2	3	4	5	9	7	8	9	10	
30	Depreciation			63,286	63,286		63,286	1,449	64,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,031	25,031		25,031	(18,016)	7,015			32
33	Real Estate Taxes			1,547	1,547		1,547	(1,547)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,715	40,715		40,715		40,715			35
36	Other (specify):*											36
37	TOTAL Ownership			130,579	130,579		130,579	(18,114)	112,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,243	391,978	499,221		499,221		499,221			36
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,843	162,843		162,843		162,843			42
43	Other (specify):* Non-Allowable Cos			61,208	61,208		61,208	(61,208)				43
44	TOTAL Special Cost Centers		107,243	616,029	723,272		723,272	(61,208)	662,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,992,969	424,724	1,480,528	3,898,221		3,898,221	(105,755)	3,792,466			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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,892)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,449	30		9
10	Interest and Other Investment Income	(18,016)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(55)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(488)	43		24
25	Fund Raising, Advertising and Promotional	(5,206)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(80,547)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,755)		$	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))**	$ (105,755)		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heartland Manor Nursing Ctr

ID# 0002923

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	$ (7,044)	43	1
2	Non Care Real Estate Taxes	(1,547)	33	2
3	Revenue Offset to Food	(19,026)	2	3
4	Part B Contractual Discount	(45,578)	43	4
5	Revenue Offset to Misc Exp	(5,813)	21	5
6	Expense Improvements under $2500 to R&M	2,400	6	6
7	To reclass labor from R&M to BI	(2,187)	6	7
8	Nonallowable PAC Dues	(1,716)	20	8
9	Revenue Offset to Rental Income	(36)	5	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**	(80,547)		49

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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
N/A	N/A	N/A		N/A		N/A

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 [X] 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			$	N/A		$	$	1
2	V								2
3	V								3
4	V								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			$			$	$ * 0	14

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Brown	President	Administrative	0.00	NA	NA	NA	NA	$ NA	N/A	1
2	Marcia Vidoni	Vice-President	Administrative	0.00	NA	NA	NA	NA	NA	N/A	2
3	Erik Huddlestun	Secretary	Administrative	0.00	NA	NA	NA	NA	NA	N/A	3
4	Sarah Holsapple-Miller	Director	Administrative	0.00	NA	NA	NA	NA	NA	N/A	4
5	Mike Kirk	Director	Administrative	0.00	NA	NA	NA	NA	NA	N/A	5
6	Ginny Collins-Knierim	Director	Administrative	0.00	NA	NA	NA	NA	NA	N/A	6
7	Bob Dougherty	Director	Administrative	0.00	NA	NA	NA	NA	NA	NA	7
8											8
9	*None of the board members have conducted buiness with the facilty.										9
10	*None of the board members have business that have conducted business with the facility.										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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3		N/A								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	TOTALS					$	$		$	25

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	Preferred Bank		X	Line of Credit	None	8/31/2013	600,000	450,000	8/30/2014	0.0600	23,410	6
7												7
8	Various		X	Finance Charges							1,621	8
9	TOTAL Facility Related						$ 600,000	$ 450,000			$ 25,031	9
	B. Non-Facility Related*											
10								Less : Interest Income Offset			(16,395)	10
11								Non-Allowable Finance Charges			(1,621)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (18,016)	14
15	TOTALS (line 9+line14)						$ 600,000	$ 450,000			$ 7,015	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** 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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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.)**	**Allocated from Managment Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009		8
	2010		9
	2011		10
	2012	N/A	11
	2013		12

Facility is a not for profit entity and is exempt from real estate taxes.

Real estate taxes are paid on non care assets; however, the tax is adjusted out of the cost report per instructions

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Ctr COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT Penny Chrysler, Administrator

TELEPHONE (217) 932-4081 FAX #: (217) 932-4922

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on non-care assets; all		$	$
2.	costs are adjusted out of cost report.		$	$
3.			$	$
4.	03-11-19-08-203-046	Lots 8&9 Sturdevant & Goble Addtn	$ 378.56	$
5.	03-11-19-08-203-047	Lots 4&5 Sturdevant & Goble Addtn	$ 1,649.30	$
6.	03-11-19-08-203-049	Lot 2 Sturdevant & Goble Addtn	$ 1,974.28	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,002.14	$

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? X YES _____ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	Resident Care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	60		1964	1964	$ 385,838	$	25	$	$	$ 385,838	4
5			1966	1966	8,491		25			8,491	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	11,798		25			11,798	7
8	21		1996	1996	828,949	20,724	40	20,724		373,033	8
	Improvement Type**										
9	Building improvements			1973	7,123		10			7,123	9
10	Building improvements (less disposition of $1,076 in '07-'08)			1974	27,871		14-30			27,871	10
11	Building improvements (less disposition of $1,773 in 2005-06)			1975	5,291		10-30			5,291	11
12	Building improvements			1976	1,607		10-30			1,607	12
13	Building improvements			1977	1,808		7			1,808	13
14	Building improvements (less disposition of $4,880 in 2006-07)			1978	1,281		5-15			1,281	14
15	Building improvements			1979	949		10			949	15
16	Building improvements			1980	5,829		7			5,829	16
17	Building improvements			1981	1,376		7			1,376	17
18	Building improvements			1982	11,926		3-30			11,926	18
19	Building improvements			1983	6,263		5			6,263	19
20	Building improvements (less disposition of $1,974 in 2004-05)			1984	16,740		5-15			16,740	20
21	Building improvements (less disposition of $480 in 2005-06)			1985	5,320		5-15			5,320	21
22	Building improvements (less disposition of $28,007 in 2005-06)			1986	17,785		10-20			17,785	22
23	Building improvements (less disposition of $157 in 2006-07)			1987	27,530		5-15			27,530	23
24	Building improvements			1988	4,282		12-15			4,282	24
25	Building improvements (less disposition of $610 in '07-'08)			1989	2,259		15			2,259	25
26											26
27	Building improvements (less disposition of $2,795 in 2002-03)			1991	631		10			631	27
28	Heating/air system			1992	80,277		20			80,277	28
29	Building improvements			1992	3,084		10			3,084	29
30	Building improvements			1992	2,168		10			2,168	30
31											31
32	Building improvements			1992	647		10			647	32
33	Building improvements			1992	4,263		15			4,263	33
34	Ceiling/floor			1992	49,923		20			49,923	34
35	Sprinkler system			1992	60,121		20			60,121	35
36	Storage shelving			1993	4,090		10			4,090	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 Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	Storage shelving	1993	$ 1,003	$	10	$	$	$ 1,003	37
38	Resident security system	1993	3,909		20			3,909	38
39	Cabinets	1993	42,611		15-20			42,611	39
40	Heating/air/tubs	1993	29,226	733	20	733		29,226	40
41	Fire alarm system	1993	12,350		20			12,350	41
42	Plumbing and water system	1993	8,684		20			8,684	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	477	20	517	40	10,198	44
45	Building improvements	1995	22,859		10-20			22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		32,278	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		13,138	48
49	Sprinklers	1996	9,774	244	40	244		4,148	49
50	Painting	1996	4,052	101	40	101		1,580	50
51	General contractor fees	1996	7,841	196	40	196		3,332	51
52	Electrical	1996	18,390	460	40	460		7,607	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		11,215	53
54	Cubicle curtain tracking	1996	742	37	20	37		673	54
55	Room signs	1996	3,331	167	20	167		3,003	55
56	Emergency lighting Jones wing	1996	142	7	20	7		130	56
57	Bath systems Jones wing	1996	8,610	431	20	431		7,755	57
58	Sprinklers Jones wing	1996	340		10			340	58
59	Security locks Jones wing	1996	1,049	52	20	52		939	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		1,692	61
62	Air filtration Jones wing	1996	2,081	104	20	104		1,872	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750		10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		2,003	65
66	Plumbing	1996	4,640	130	20	232	102	4,376	66
67	Electrical work (less disposition of $1,500 in 2005-06)	1996	3,162		20			3,162	67
68	Flooring	1996	2,400	120	20	120		2,140	68
69	Courtyard	1996	2,766	138	20	138		2,476	69
70	TOTAL (lines 4 thru 69)		$ 1,919,114	$ 27,589		$ 27,731	$ 142	$ 1,373,191	70

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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		$ 1,919,114	$ 27,589		$ 27,731	$ 142	$ 1,373,191	1
2	Concrete work entrance	1996	1,470	74	20	74		1,314	2
3	Building appraisal	1997	2,578	64	40	64		384	3
4	Chapel HVAC	1997	2,324	116	20	116		2,035	4
5	Stained glass window	1997	2,052	103	20	103		1,772	5
6	Steel door	1997	422	21	20	21		362	6
7									7
8									8
9	Hand rails	1997	5,252	263	20	263		4,466	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		9,746	11
12	Fire system work	1997	513	26	20	26		434	12
13	Key pad - security system	1997	360	18	20	18		303	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		754	15
16									16
17	Bed light installation	1998	1,826	91	20	91		1,489	17
18	Hand rails	1998	1,413	71	20	71		1,150	18
19	Sprinklers	1998	708	35	20	35		573	19
20	Generator bypass switch	1998	1,567	78	20	78		1,265	20
21									21
22	Lighting - kitchen	1998	985		20			546	22
23	Paging system	1998	516	26	20	26		412	23
24	Room divider remodeling	1998	391	20	20	20		314	24
25	Bathroom lighting	1998	1,090	27	20	55	28	865	25
26	South wing remodeling	1998	165	8	20	8		56	26
27	Roof over generator room	1998	568	28	20	28		447	27
28	Bathrooms	1998	7,394	370	20	370		5,825	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		4,840	29
30	Fire Alarm System	1999	1,317	66	20	66		1,005	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		1,254	31
32		1999	1,760	44	20	88	44	1,335	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,974,070	$ 30,152		$ 30,366	$ 214	$ 1,416,137	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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		$ 1,974,070	$ 30,152		$ 30,366	$ 214	$ 1,416,137	1
2	Generator panel	2000	2,023		10			2,023	2
3	Gazebo	2000	2,733		10			2,733	3
4	Anti-scald valves (2)	2001	655		10			655	4
5	Shower floor replacement	2001	500	25	20	25		338	5
6	Dining room lights	2001	6,013	150	20	301	151	4,061	6
7									7
8	Toilet stools & seats	2001	1,414		10			1,414	8
9	Parking lot asphalt reseal	2001	5,032	252	20	251	(1)	3,204	9
10	Ceramic wall tile	2001	365	18	20	18		231	10
11	Washer & nurse call	2001	485		10			485	11
12	Bath fans	2001	150		10			150	12
13	Extend legs on links	2001	607		10			607	13
14	Wallpaper front lobby	2001	150		10			150	14
15	Remodel North & South showers	2002	2,332	117	20	116	(1)	1,425	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912		10			912	16
17	Water heater	2002	4,165	104	20	208	104	2,515	17
18									18
19	Compressor - freezer	2002	810		10			810	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		363	20
21	Carpet	2003	2,887	144	20	144		1,694	21
22	Bypass switch for generator	2003	2,166	108	20	108		1,207	22
23	Sign	2003	850		10			850	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		2,009	25
26	Water Heater	2004	6,548	327	20	327		3,463	26
27	Wireless Monitoring System	2004	4,263	215	10	215		4,263	27
28	Water heater	2004	3,475	174	20	174		1,811	28
29	Lights, smoke detectors, other	2004	2,562	193	10	193		2,562	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		$ 2,033,608	$ 32,220		$ 32,687	$ 467	$ 1,456,072	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,033,608	$ 32,220		$ 32,687	$ 467	$ 1,456,072	1
2	Security fence (less disposition of $2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		2,638	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		2,640	4
5	Windows - South Wing	2005	5,499	275	15	275		2,681	5
6	Windows - H Wing	2005	4,132	207	20	207		2,000	6
7	Handrails	2005	1,375	92	20	92		880	7
8	2 ton compressor	2005	558	37	15	37		409	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		5,731	10
11	Generator	2005	20,000	2,000	10	2,000		17,000	11
12									12
13	Roof	2006	10,657	273	39	273		2,184	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		1,119	14
15									15
16	Roof Repair	2008	4,587	167	27.5	167		1,002	16
17									17
18	Canopy Sprinkler System	2008	9,685	646	15	646		3,768	18
19	Jones Wing Door Alarms	2008	3,706	124	15	247	123	1,379	19
20	Hutton Wing New Doors	2009	5,100	340	15	340		1,870	20
21									21
22	Light Fixtures-All Areas	2010	19,737	1,038	20	987	(51)	4,030	22
23									23
24	Water Heater	2011	4,153	208	20	208		728	24
25	Door	2011	2,955	148	15	197	49	690	25
26									26
27	Backup Generator Meter	2011	3,467	173	20	173		433	27
28									28
29	Kitchen A/C Unit	2012	7,084	472	15	472		1,180	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,161,456	$ 39,789		$ 40,377	$ 588	$ 1,508,434	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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 12D, Carried Forward		$ 2,161,456	$ 39,789		$ 40,377	$ 588	$ 1,508,434	1
2									2
3	Water Heater	2013	4,385	219	20	219		329	3
4	Generator Transfer Switch	2013	2,965	148	20	148		222	4
5	Condensing Unit for Walkway	2013	4,768	318	15	318		477	5
6									6
7	Landscaping & fountain in front of facility	2014	7,280	182	20	182	0	182	7
8	Installation of digital phone system	2014	6,262		5	626	626	626	8
9	Wiring and labor for installation of EHR capability	2014	7,241	30	20	181	151	181	9
10	Replace condenser on A/C - Dining Room Area	2014	3,323	12	20	83	71	83	10
11	Front office remodel: carpet, paint & tiling	2014	3,157	23	20	79	56	79	11
12									12
13									13
14	To reconcile to financial statements			(7)			7		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)		$ 2,200,837	$ 40,714		$ 42,213	$ 1,499	$ 1,510,613	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$ 157,498	$ 20,836	$ 20,836	$	3-20	$ 110,144	71
72	Current Year Purchases	12,056	1,269	986	(283)	5-10	986	72
73	Fully Depreciated Assets	427,551					427,551	73
74								74
75	TOTALS	$ 597,105	$ 22,105	$ 21,822	$ (283)		$ 538,681	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	Resident Care	1994 Ford Van	1995	$ 41,610	$	$	$	5	$ 41,610	76
77	Resident Care	2005 Chevy Venture Van	2014	7,000	467	700	233	5	700	77
78										78
79										79
80	TOTALS			$ 48,610	$ 467	$ 700	$ 233		$ 42,310	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)	$ 2,870,552	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,286	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,735	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,450	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,091,604	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	See Schedule 13A Attached	$ 161,400	$ 2,185	$ 115,794	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 161,400	$ 2,185	$ 115,794	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: **Heartland Manor Nursing Ctr**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2014**

Schedule 13A

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

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Aklinski Building	1994	40,045	1,027		(1,027)		20,279
	Aklinski concrete work	1994	3,900	195		(195)		3,445
	Land		30,000			-		30,000
	Repp House	1998	38,500	963		(963)		13,115
	Architect fees for Assisted Living	2005	2,915			-		2,915
	410 NW 3 rd Street - Land		46,040			-		46,040
						-		
						-		
						-		
						-		
						-		
TOTAL			**161,400**	**2,185**	**-**	**(2,185)**		**115,794**

*The decrease in Depreciable Non-Care Assets is due to the disposable/sale of assets.

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 40,715 Description: Please see SCH 14A
    (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			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	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: **Heartland Manor Nursing Ctr**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Dishwasher	680
Washer/Dryer	3,340
Mattresses	7,690
Oxygen Equipment	19,902
Wound Vac	7,490
CPM Units	4,000
Remove Carry Forward	(2,388)
Total - Line 16	**40,715**

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

It is the policy of this facility to only hire certified nurses aides.

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.

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	Ln 39, C3	hrs	$	2,158	$ 133,014	$	2,158	$ 133,014	1
2	Licensed Speech and Language Development Therapist	Ln 39, C3	hrs		279	17,395		279	17,395	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 39, C3	hrs		3,879	241,569		3,879	241,569	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				90,119		90,119	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Ther Supplies &	L39, C2					17,124		17,124	12
13	Other (specify):									13
14	TOTAL			$	6,316	$ 391,978	$ 107,243	6,316	$ 499,221	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.

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014 (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	$ 95,433	$ 95,433	1
2	Cash-Patient Deposits	7,456	7,456	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	1,039,611	1,039,611	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,973	22,973	9
7	Other Prepaid Expenses	39,105	39,105	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,204,578	$ 1,204,578	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,151	20,151	12
13	Land	120,585	24,000	13
14	Buildings, at Historical Cost	2,177,512	2,200,837	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	615,423	645,715	19
17	Accumulated Depreciation (book methods)	(1,986,559)	(2,091,604)	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 **Security Deposits**	334	334	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 947,446	$ 799,433	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,152,024	$ 2,004,011	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 225,503	$ 225,503	29
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,556	7,556	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,809	139,809	30
31	Accrued Taxes Payable (excluding real estate taxes)	97,932	97,932	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	43,390	43,390	39
37				37
38	**TOTAL Current Liabilities (sum of lines 29 thru 37)**	$ 514,190	$ 514,190	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	450,000	450,000	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)**	$ 450,000	$ 450,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 964,190	$ 964,190	49
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,187,834	$ 1,039,821	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 49 and 47)**	$ 2,152,024	$ 2,004,011	48

***(See instructions.)**

Facility Name: **Heartland Manor Nursing Ctr**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2014**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Account	Description	Operating	After Consolidation
110205	Accts Rec - Dual Eligible	43,118	43,118
110218	Balance Transfer Clearing Account	76	76
110219	Patient Refund Clearing Account	71	71
210114	Unearned Room Revenue	(234)	(234)
210110	Insurance Payables	(815)	(815)
210109	401k Payables	489	489
210112	Employee Deductions- Credit Union	685	685
	Total - Line 36	**43,390**	**43,390**

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,292,923	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(210,854)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,082,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,765	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)**	$ 105,765	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,187,834	24 *

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

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$ 3,027,191	1
2	Discounts and Allowances for all Levels	(94,111)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,933,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	852,773	9
7	Oxygen	19,450	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 872,223	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		13
14	Non-Patient Meals	19,026	14
15	Telephone, Television and Radio	2,184	15
16	Rental of Facility Space	10,175	19
17	Sale of Drugs	85,698	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,587	19
20	Radiology and X-Ray	390	20
21	Other Medical Services	42,524	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 165,584	23
	D. Non-Operating Revenue		
24	Contributions	9,268	24
25	Interest and Other Investment Income***	16,395	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,663	29
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	7,436	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,436	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 29 and 29)**	$ 4,003,986	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	765,588	31
32	Health Care	1,538,636	32
33	General Administration	740,146	33
	B. Capital Expense		
34	Ownership	130,579	34
	C. Ancillary Expense		
35	Special Cost Centers	560,429	35
36	Provider Participation Fee	162,843	39
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,898,221	40
41	**Income before Income Taxes (line 30 minus line 40)****	105,765	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 105,765	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,140,062	44
45	Private Pay - Net Inpatient Revenue	1,337,526	45
46	Medicare - Net Inpatient Revenue	455,492	49
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,933,080	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

"^-This entity is a cash basis taxpayer"

Facility Name: **Heartland Manor Nursing Ctr**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2014**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Account	Description	Amount
560500	Recovery of Bad Debts	-
320700	Adult Day Care	240
568000	Oil Income	1,383
569000	Miscellaneous Income	5,813
	Total - Line 28	**7,436**

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 54,878	$ 26.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,270	7,891	178,067	22.57	3
4	Licensed Practical Nurses	21,903	23,391	419,001	17.91	4
5	CNAs & Orderlies	52,377	54,869	603,063	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,984	2,080	26,744	12.86	9
10	Activity Assistants	2,652	2,842	27,937	9.83	10
11	Social Service Workers	3,753	4,006	50,126	12.51	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	29,227	14.05	13
14	Head Cook	5,731	6,470	84,702	13.09	14
15	Cook Helpers/Assistants	13,960	15,076	135,835	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,541	3,884	55,652	14.33	17
18	Housekeepers	6,278	7,009	65,186	9.30	18
19	Laundry	6,593	7,122	63,126	8.86	19
20	Administrator	1,960	2,080	57,715	27.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,052	6,436	87,337	13.57	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	1,774	1,945	19,686	10.12	31
32	Other Health Ca					32
33	Other(specify) MDS Coordinator	1,946	2,241	34,687	15.48	33
34	TOTAL (lines 1 - 33)	141,550	151,502	$ 1,992,969 *	$ 13.15	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	96	$ 5,523	L1, C3	35
36	Medical Director	Monthly	9,263	L9, C3	36
37	Medical Records Consultant	16	1,960	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,020	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,794	L11, C3	44
45	Social Service Consultant	48	1,794	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	208	$ 21,354		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	42	1,781	Ln 10, C3	51
52	Certified Nurse Assistants/Aides	18	166	Ln 10, C3	52
53	TOTAL (lines 50 - 52)	60	$ 1,947		53

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Chrysler	Administrator	0	$ 57,715
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,715

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$ 0
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Quorum Consulting Group	401(k) Administrator	$ 2,874
McGladrey LLP	Accounting	12,035
Larson, Woodyard & Henson LLP	Accounting	26,830
Duane Morris	Legal	54,444
James Grant	Legal	75
Resch Siemer Law Office, LLC	Legal	55
Am Healthtech	Consulting	5,374
Personal Planners	Consulting	1,486
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 103,173

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,768
Unemployment Compensation Insurance	
FICA Taxes	190,945
Employee Health Insurance	104,537
Employee Meals	6,248
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	24,976
Labs & Physicals	2,623
Employee Life Insurance	3,072
TOTAL (agree to Schedule V, line 22, col.8)	$ 376,169

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	80
Health Care Worker Background Check	
(Indicate # of checks performed 90)	
Patient Background Checks	1,440
Miscellaneous Licenses & Fees	509
Miscellaneous Dues & Subscriptions	10,691
IL Healthcare Assoc. Dues	4,471
Less: Public Relations Expense	( )
Non-allowable advertising	(1,716)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,465

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,480
Seminar Expense	403
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,883

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Heartland Manor Nursing Ctr**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2014**

Schedule 21A

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
	Total (agree to Schedule V, line 19, column 3)	103,173
Less: Non-Allowable Legal Fees		(55)
	Total (agree to Schedule V, line 19, column 8)	103,118

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Manor Nursing Ctr # 0002923 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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. **Illinois Health Care Assoc. $4,471**

(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? **N/A**

(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? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,706** Line **L10, C2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **162,843**
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. $ **6,248** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **19,026**

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

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Larson, Woodyard & Henson CPA**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.