



Facility Name & ID Number Heartland of Champaign

# 0049395 Report Period Beginning: 06/01/13 Ending: 05/31/14

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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,475	7,051	15,081	29,607	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,475	7,051	15,081	29,607	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.52%

D. How many bed-hold days during this year were paid by the Department?

0 (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 11/01/81

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 102 and days of care provided 9,886

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name &amp; ID Number

Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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
	<b>A. General Services</b>										
1	Dietary	100,732	33,234	249,142	383,108		383,108	383,108			1
2	Food Purchase		278,348		278,348		278,348	(22,608)	255,740		2
3	Housekeeping	121,178	15,160	19,579	155,917		155,917		155,917		3
4	Laundry	48,669	15,348	11,031	75,048		75,048		75,048		4
5	Heat and Other Utilities			147,828	147,828	1,761	149,589		149,589		5
6	Maintenance	52,626	25,419	151,964	230,009		230,009		230,009		6
7	Other (specify):* <b>Med Waste</b>			688	688		688		688		7
8	<b>TOTAL General Services</b>	323,205	367,509	580,232	1,270,946	1,761	1,272,707	(22,608)	1,250,099		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,847	20,847		20,847		20,847		9
10	Nursing and Medical Records	2,403,470	217,485	83,691	2,704,646	7,675	2,712,321		2,712,321		10
10a	Therapy	1,152,118	12,300	41,417	1,205,835		1,205,835		1,205,835		10a
11	Activities	49,967	5,619	270	55,856		55,856		55,856		11
12	Social Services	142,451		2,903	145,354		145,354		145,354		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,748,006	235,404	149,128	4,132,538	7,675	4,140,213		4,140,213		16
	<b>C. General Administration</b>										
17	Administrative	72,539		452,575	525,114	(178,737)	346,377		346,377		17
18	Directors Fees										18
19	Professional Services			30,186	30,186		30,186	(30,186)			19
20	Dues, Fees, Subscriptions & Promotions			81,343	81,343		81,343	(40,846)	40,497		20
21	Clerical & General Office Expenses	264,832	52,945	339,743	657,520		657,520	(292,199)	365,321		21
22	Employee Benefits & Payroll Taxes			744,294	744,294	38,703	782,997		782,997		22
23	Inservice Training & Education			3,984	3,984		3,984		3,984		23
24	Travel and Seminar			20,827	20,827		20,827		20,827		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			194,611	194,611		194,611		194,611		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	337,371	52,945	1,867,563	2,257,879	(140,034)	2,117,845	(363,231)	1,754,614		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,408,582	655,858	2,596,923	7,661,363	(130,598)	7,530,765	(385,839)	7,144,926		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 &amp; ID Number

Heartland of Champaign

#0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			196,148	196,148	13,026	209,174		209,174			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			823,660	823,660	117,572	941,232	(848,663)	92,569			32
33	Real Estate Taxes			66,858	66,858		66,858		66,858			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			122,000	122,000		122,000		122,000			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,208,666	1,208,666	130,598	1,339,264	(848,663)	490,601			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		837,388	3,538	840,926		840,926		840,926			39
40	Barber and Beauty Shops			7,731	7,731		7,731		7,731			40
41	Coffee and Gift Shops	53,961			53,961		53,961		53,961			41
42	Provider Participation Fee			175,835	175,835		175,835		175,835			42
43	Other (specify):*		79,069	209,861	288,930		288,930		288,930			43
44	<b>TOTAL Special Cost Centers</b>	53,961	916,457	396,965	1,367,383		1,367,383		1,367,383			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,462,543	1,572,315	4,202,554	10,237,412		10,237,412	(1,234,502)	9,002,910			45

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

Facility Name & ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

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**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(22,608)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(164)	21		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	(23,790)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(25,373)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(257,389)	21		24
25	Fund Raising, Advertising and Promotional	(40,846)	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	(864,332)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,234,502)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,234,502)</b>		<b>37</b>

\*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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Heartland of Champaign

ID# 0049395

Report Period Beginning: 06/01/13

Ending: 05/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ (848,663)	32	1
2	Vending Income	(1,496)	21	2
3	Accounting / Collection Fees	(4,813)	19	3
4	Misc Income	(9,360)	21	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
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	<b>Total</b>	(864,332)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	(22,608)	0	0	0	0	0	0	0	0	0	0	(22,608)	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	<b>TOTAL General Services</b>	<b>(22,608)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(22,608)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(30,186)	0	0	0	0	0	0	0	0	0	0	(30,186)	19
20	Fees, Subscriptions & Promotions	(40,846)	0	0	0	0	0	0	0	0	0	0	(40,846)	20
21	Clerical & General Office Expenses	(292,199)	0	0	0	0	0	0	0	0	0	0	(292,199)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(363,231)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(363,231)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(385,839)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(385,839)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Champaign# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	(848,663)	0	0	0	0	0	0	0	0	0	0	(848,663)	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	<b>TOTAL Ownership</b>	<b>(848,663)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(848,663)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(1,234,502)	0	0	0	0	0	0	0	0	0	0	(1,234,502)	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 Svc	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
		See Pg 6 Supp for list of related nursing homes in Illinois				

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						1
2	V	Page 8						2
3	V							3
4	V	1-44						4
5	V	10a						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		\$ 4,910,120			\$ 4,910,120	\$ *	14

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

Facility Name & ID Number

Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

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 Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

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 Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				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

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	9
					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	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 Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending: 05/31/14

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

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

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

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	3,919,925,578	702 NFs, HHs, & R	\$ 702,082	\$ 9,829,606	\$ 1,761	1	
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs		9,829,606	0	2	
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs		9,829,606	0	3	
4	10	Nursing - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	421,070	303,971	9,829,606	1,056	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	2,331,970	10,787,378	9,829,606	6,619	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs		9,829,606	0	6	
7	17	Gen / Admin - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	66,712,258	34,047,414	9,829,606	167,287	7
8	17	Gen / Admin - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	18,712,683	6,531,152	9,829,606	53,111	8
9	17	Gen/Admin-Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs	1,887,403	1,136,236	9,829,606	37,540	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	7,831,139		9,829,606	19,637	10
11	22	Empl Benefits - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	6,717,577		9,829,606	19,066	11
12	22	Empl Benefits-Dir to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			9,829,606	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	4,454,722		9,829,606	11,171	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	653,747		9,829,606	1,855	14
15	30	Depr - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			9,829,606	0	15
16										16
17	32	Pooled Interest	Accumulated Cost	3,919,925,578		25,923,280		9,829,606	65,005	17
18	32	Directly Assigned Interest	Not Allocated			18,563,246			52,567	18
19										19
20		H/O Costs Allocated to Non-SNFs & Oth Div				30,324,259				20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 185,235,436	\$ 52,806,151	\$ 436,675		25

Facility Name & ID Number

Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Conv Sub Debentures		X	Various			\$ 802,268	\$ 802,268		0.0655	\$ 52,567						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6																	
7	Pooled Interest										65,005						
8	Interest Expense / Interest Income										(25,003)						
9	<b>TOTAL Facility Related</b>						\$ 802,268	\$ 802,268			\$ 92,569						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 802,268	\$ 802,268			\$ 92,569						

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**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>																																				
1. Real Estate Tax accrual used on 2013 report.		\$ <b>59,671</b>	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.)		\$ <b>65,717</b>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>6,046</b>	3																																	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>60,812</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>66,858</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2009</td><td><u>60,769</u></td><td>8</td></tr> <tr><td>2010</td><td><u>61,811</u></td><td>9</td></tr> <tr><td>2011</td><td><u>62,362</u></td><td>10</td></tr> <tr><td>2012</td><td><u>65,096</u></td><td>11</td></tr> <tr><td>2013</td><td><u>66,340</u></td><td>12</td></tr> </table>	2009	<u>60,769</u>	8	2010	<u>61,811</u>	9	2011	<u>62,362</u>	10	2012	<u>65,096</u>	11	2013	<u>66,340</u>	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2013</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			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
2009	<u>60,769</u>	8																																		
2010	<u>61,811</u>	9																																		
2011	<u>62,362</u>	10																																		
2012	<u>65,096</u>	11																																		
2013	<u>66,340</u>	12																																		
<b>FOR BHF USE ONLY</b>																																				
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																																	
<b>Line 2: \$65,717.80 = \$32,547.78 for 2nd half of 2012 + \$33,170.02 for 1st half 2013</b>																																				
<b>Line 4: \$60,811.69 = \$33,170.02 for 2nd half of 2013 + \$27,641.67 for Jan - May 2014</b>																																				

**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 of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0049395

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

**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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>42-21-18-103-011</u>	<u>See Attached</u>	\$ <u>1,949.12</u>	\$ <u>1,949.12</u>
2. <u>42-21-18-103-020</u>	<u>See Attached</u>	\$ <u>2,426.00</u>	\$ <u>2,426.00</u>
3. <u>46-21-18-103-021</u>	<u>See Attached</u>	\$ <u>2,559.38</u>	\$ <u>2,559.38</u>
4. <u>42-21-18-103-005</u>	<u>See Attached</u>	\$ <u>2,626.08</u>	\$ <u>2,626.08</u>
5. <u>46-21-18-103-012</u>	<u>See Attached</u>	\$ <u>3,378.94</u>	\$ <u>3,378.94</u>
6. <u>46-21-18-103-003</u>	<u>See Attached</u>	\$ <u>53,400.52</u>	\$ <u>53,400.52</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>66,340.04</u></u>	\$ <u><u>66,340.04</u></u>

**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 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 of Champaign

# 0049395 Report Period Beginning:

06/01/13 Ending:

05/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,745 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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).

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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	<u>Facility</u>		<u>1968</u>	<u>\$ 54,050</u>	<u>1</u>
2			<u>2007</u>	<u>249,936</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 303,986</b>	<b>3</b>

Facility Name & ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	Accumulated Depreciation
4	102		1968	\$ 1,201,229	\$ (11,217)		\$ (11,217)	\$ 1,277,744
5								
6								
7								
8								
<b>Improvement Type**</b>								
9	Current Year Depreciation				126,629		126,629	2,726,892
10			1985	3,107				
11			1986	8,851				
12			1987	74,516				
13			1987	(55,068)				
14			1988	41,139				
15			1989	1,297				
16			1990	20,319				
17			1991	50,575				
18			1992	374,174				
19	RETIREMENTS		1992	(6,784)				
20			1993	51,354				
21			1994	48,400				
22			1995	229,982				
23	ELECTRICAL WORK		1996	17,102				
24	WALL VINYL		1996	10,548				
25	VINYL FLOORING		1996	14,858				
26	INSTALL CAMERA SYSTEM		1996	1,453				
27	REMODEL 13 ROOMS AND LOBBY		1996	35,665				
28	HVAC		1996	21,101				
29	ROOF WORK		1996	1,365				
30	CORPORATE OVERHEAD-13 ROOMS/LOBBY		1996	7,272				
31	CONCRETE WORK		1996	3,880				
32	CARPET		1996	5,900				
33	DIGITAL KEYPAD		1996	1,915				
34	INSTALL EMERGENCY GENERATOR		1996	44,791				
35	INSTALL CIRCUIT BREAKER		1996	3,289				
36	HVAC		1996	1,867				

\*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 &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	
37	INSTALL COVE BASE/SIGNS	1996	\$ 2,612	\$		\$	\$	\$	37
38	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)						38
39	WALLCOVERINGS	1997	12,165						39
40	CARPET	1997	1,639						40
41	INSTALL HYDROLIC CYLINDER	1997	14,249						41
42	UNIT PROTECTION SWITCH	1997	6,354						42
43	FURNISH/INSTALL TILES	1997	16,476						43
44	HANDRAILS	1997	5,661						44
45	PLUMBING	1997	7,610						45
46	VINYL TILE	1997	1,643						46
47	HAND RAILS	1997	1,450						47
48	FACILITY PLAN ALLOC	1997	2,759						48
49	INSTALL GATES	1997	1,226						49
50	CORNER GUARDS	1997	314						50
51	C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)						51
52	ELECTRICAL	1998	2,598						52
53	REPLACE WINDOWS	1998	2,763						53
54	INSTALL QUARRY TILE	1998	1,640						54
55	INSTALL DUCTWORK	1998	2,350						55
56	CORPORATE OVERHEAD	1998	1,702						56
57	SECURITY SYSTEM	1998	33,542						57
58	ENTRYWAY/PARKING LOT WORK	1998	2,209						58
59	ELEVATOR EQUP EVAL	1998	700						59
60	CARPENTRY	1998	355						60
61	WALLPAPER	1998	400						61
62	CARPETING/FLOORING	1998	2,471						62
63	PLUMBING	1998	9,690						63
64	ELECTRICAL	1998	1,367						64
65	HVAC	1998	565						65
66	PAINTING/WALLCOVERING	1998	10,552						66
67	GENERAL REQ	1998	1,500						67
68	CONTRACTORS	1998	2,507						68
69	ROOFING	1998	500						69
70	TOTAL (lines 4 thru 69)		\$ 2,355,636	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	70

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

Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,355,636	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)						2
3	DOOR/WINDOW	1998	2,456						3
4	ELEVATORS	1998	3,433						4
5	SIGNAGE	1998	11,862						5
6	CARPETING	1999	5,993						6
7	CALL LIGHT SYSTEM	1999	42,342						7
8	1997 BILLING FOR CONSTRUCTION	1999	20,476						8
9	INSTALL SECURE DOOR KIT	1999	3,753						9
10	FABRIC FOR PATIENT FURNITURE	1999	121						10
11	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(121)						11
12	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						12
13	FABRIC FOR PATIENT FURNITURE	1999	674						13
14	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(674)						14
15	PAINT, WALLPAPER, CORRIDOR	1999	8,471						15
16	FIRE-SMOKE DAMPERS	1999	(581)						16
17	REMODEL KITCHEN RECEPTACLES	1999	4,800						17
18	NEW SHOWER BASE	1999	6,870						18
19	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						19
20	CERAMIC TILE - 2 SHOWERS	1999	2,718						20
21	FIRE & SMOKE DAMPERS	1999	9,527						21
22	PROCARE 1000 NURSE CALL	1999	17,494						22
23	ZSN REPAIR	1999	1,307						23
24	DRAIN REPLACEMENT	2000	875						24
25	DRYWALL REPAIR	2000	600						25
26	CONTROL PANEL REPLACED	2000	984						26
27	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						27
28	WALLCOVERINGS	2000	364						28
29	VINYL WALLCOVERINGS	2000	1,662						29
30	WALLCOVERING	2000	1,566						30
31	CLOSET DOORS	2000	13,140						31
32	WALLCOVERING	2000	37						32
33	WALLCOVERING - DINING RM	2000	1,769						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,521,510	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	34

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

Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,521,510	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						2
3	CORNER GUARDS	2000	17						3
4	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						4
5	WALLCOVERING	2000	270						5
6	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						6
7	C/R 5/31/03 AUDIT ADJ #1a - Developers Cost	2000	(4,708)						7
8	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						8
9	VCT	2000	3,230						9
10	WIRING - ACTIVITY & REC RM	2000	1,412						10
11	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						11
12	PAINTING CLOSET DOORS	2000	8,000						12
13	SINK, FAUCET & PLUMBING	2000	1,985						13
14	ARCADIA HALL BATH	2000	3,933						14
15	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						15
16	CLOSET DOORS	2000	7,640						16
17	SHOWER-CERAMIC TILE	2000	302						17
18	CLOSET DOOR - RETAINAGE	2000	1,460						18
19	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						19
20	2 NURSE STATIONS	2001	12,826						20
21	BORDER	2001	210						21
22	VCT	2001	1,130						22
23	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						23
24	DOORS	2001	8,985						24
25	CARPET	2001	1,053						25
26	CEILING TILE	2001	28,650						26
27	SHOWER RENOVATION	2001	13,048						27
28	PAINTING	2001	765						28
29	COURTYARD RENOVATIONS	2001	4,775						29
30	COURTYARD RENOVATIONS	2001	5,120						30
31	DOORS	2002	746						31
32	CARPET	2002	995						32
33	WALL TILE FOR SHOWER	2002	1,840						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,645,205	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	34

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

Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

## 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 12C, Carried Forward		\$ 2,645,205	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	MILLWORK, ELECTRICAL	2002	14,351						2
3	CARPET	2002	1,686						3
4	Freight on Carpet	2002	73						4
5	VWC	2002	282						5
6	3 Heavy Duty Doors	2002	3,574						6
7	C/R 5/31/03 AUDIT ADJ #1b - Overhead & Interest	2002	(5,444)						7
8	Painting, VWC, and Flooring	2002	1,098						8
9	Painting, VWC, and Flooring	2002	524						9
10	Renovation - Electrical 5/31/03 Audit Adj #2a Change Year	2002	87,505						10
11	Arch Engineering Costs	2002	1,018						11
12	freight on vwc	2002	9						12
13	general construction	2002	1,169						13
14	Freight on Carpet	2002	112						14
15	Carpet	2002	1,170						15
16	border	2002	1,254						16
17	freight on vwc	2002	20						17
18	carpet	2002	953						18
19	carpet and installation	2002	16,878						19
20	VWC	2002	140						20
21	carpet	2002	953						21
22	paint, vwc, and flooring	2002	9,357						22
23	Retro Addition	2002	(231)						23
24	VWC	2003	2,980						24
25	Flooring	2003	445						25
26	Reno - Gen, fire, Doors&P Audit Adj #2b Change Yr 2001 & 2002	2003	60,845						26
27	C/R 5/31/03 AUDIT ADJ #2b - Overhead & Interest	2003	(60,845)						27
28	Renovation - 5/31/03 Audit Adj #2b Change Year 2001	2001	88,776						28
29	Renovation - 5/31/03 Audit Adj #2b Change Year 2002	2002	6,593						29
30	Arch Engineering Costs	2003	172						30
31	Arch Engineering Costs	2003	774						31
32	Carpet	2003	140						32
33	CARPET	2003	1,075						33
34	TOTAL (lines 1 thru 33)		\$ 2,882,610	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	34

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



Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 2,882,610	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	<b>ELEVATORS - OVERHEAD AND INTEREST</b>	2003	3,299						2
3	<b>ELEVATORS CARPENTRY</b>	2003	72,624						3
4	<b>BORDERS</b>	2003	127						4
5	<b>VWC</b>	2003	438						5
6	<b>VWC</b>	2003	4,080						6
7	<b>VWC</b>	2003	571						7
8	<b>CARPET AND INSTALLATION</b>	2003	4,190						8
9	<b>SHOWER ROOM FLOORS AND WALLS</b>	2003	6,901						9
10	<b>SHOWER ROOM FLOORS AND WALLS</b>	2003	289						10
11	<b>DEVELOPERS COSTS - OVERHEAD</b>	2004	17,971						11
12	<b>DEVELOPERS COSTS - INTEREST</b>	2004	1,099						12
13	<b>CARPETING AND PADS</b>	2004	7,249						13
14	<b>WALLCOVERINGS</b>	2004	46,392						14
15	<b>EXTERIOR LIGHT POLE</b>	2004	6,596						15
16	<b>EXTERIOR LIGHT POLE</b>	2004	687						16
17	<b>CONCRETE SLAB</b>	2005	3,115						17
18	<b>VINYL WALL COVERING</b>	2004	1,377						18
19	<b>VINYL WALL COVERING AND PAINTING</b>	2004	9,000						19
20	<b>VINYL WALL COVERING</b>	2004	938						20
21	<b>VINYL WALL COVERING &amp; PAINTING</b>	2004	1,380						21
22	<b>VINYL WALL COVERING &amp; PAINTING</b>	2004	3,420						22
23	<b>COVE BASE</b>	2004	2,160						23
24	<b>DOORS</b>	2004	5,893						24
25	<b>CARPET</b>	2004	4,275						25
26	<b>INSTALL SECURITY DOOR</b>	2005	2,910						26
27	<b>FOURTEEN ARTWORK PIECES</b>	2004	1,117						27
28	<b>ELECTRICAL WORK</b>	2005	5,926						28
29	<b>STAIR TREDS</b>	2005	5,640						29
30	<b>OVERHEAD</b>	2005	13,558						30
31	<b>INTEREST</b>	2005	805						31
32	<b>FLOORING</b>	2005	8,770						32
33	<b>WALL COVERING</b>	2005	8,050						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,133,457	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	34

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

Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

## 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		\$ 3,133,457	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	CARPENTRY	2005	1,012						2
3	FENCE	2006	5,140						3
4	FENCE	2006	882						4
5	CERAMIC TILE SHOWER	2006	3,949						5
6	CHAMPAIGN IL	2007	2,550						6
7	SIDEWALK	2008	11,430						7
8	Blgd Im - Arch & Eng Fees	2007	53,414						8
9	Blgd Im - Arch & Eng Fees	2007	205,493						9
10	WALLPAPER	2007	6,605						10
11	CEILING TILES	2007	22,683						11
12	ENGINEERING	2007	17,000						12
13	ROOF REPLACEMENT	2007	66,406						13
14	COMMON AREA FURNISHINGS	2007	316						14
15	COMMON AREA FURNISHINGS	2008	1,605						15
16	CARPET FOR 2ND/3RD FLOOR	2008	26,122						16
17	CARPET FOR 2ND/3RD FLOOR	2008	(1)						17
18	FIRE DAMPERS	2008	75,045						18
19	Renov -(Tot contracted amt) -Painting, Drywall, VWC	2009	10,350						19
20	CARPETING+PADS	2008	9,317						20
21	PAVING/SEALCOATING	2008	5,949						21
22	SEWER LINE	2009	13,911						22
23	Add'l cost Fire Dampers	2008	5,587						23
24	Fire Dampers	2008	50,285						24
25	Kitchen Storage Room Door	2009	5,283						25
26	0310 Renov - General Overhead & Interest	2010	128						26
27	0310 Renov - Carpentry - Subcontr	2010	98,201						27
28	0310 Renov - Carpeting & Pads	2010	12,368						28
29	0310 Renov - Wallcovering & Corner Guards	2010	30,901						29
30	ceramic floors	2010	3,105						30
31	exterior doors	2010	32,279						31
32	0310 Renov - Carpentry - Subcontr additional	2010	178,913						32
33	85- gal water heater	2011	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 4,100,348	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	34

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

**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	<b>Totals from Page 12F, Carried Forward</b>		\$ 4,100,348	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	1
2	fabric for chairs for 2nd & 3rd floor corridor renovation	2011	653						2
3	Frt on Fabric for 2nd & 3rd floor corridor renovation	2011	125						3
4	wallcovering for 2nd & 3rd floor corridor renovation	2011	1,761						4
5	vinyl fencing	2010	7,875						5
6	Additional cost for vinyl fencing	2010	7,875						6
7	Frt on carpet for 2nd & 3rd floor corridor renovation	2011	1,013						7
8	carpeting for 2nd & 3rd floor corridor renovation	2011	6,910						8
9	2010 Renov - Carpentry - Subcontr - Central Bath	2011	48,222						9
10	Painting	2011	8,123						10
11	FLOORING, WALL TILE INCENTRAL BATHS AND RESIDENT B	2011	14,598						11
12	FLOORING IN SOC SVC LOUNGD & RES RM 330	2011	7,807						12
13	Replace all exterior doors	2011	3,587						13
14	replace existing double door w/ single 48" door	2011	4,565						14
15	WALLCOVERINGS, FLOORING for 3rd floor resident rooms	2011	36,437						15
16	RENNOR MAKE-UP AIR UNIT	2011	63,180						16
17	ADD'L FLOORING FOR RESIDENT BATHS	2011	2,800						17
18	NEW SHEETROCK IN RECORDS RM DUE TO PLUMBING LEAK	2011	2,655						18
19	NURSE STATION SOFFIT UPGRADE	2011	6,850						19
20	REPLACE EXTERIOR DOORS & FLOORING FRONT OFFICES	2011	14,598						20
21	ELEVATOR RENOVATION	2011	37,209						21
22	WALLCOVERING FOR FRONT OFFICES	2011	36,437						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,413,626	\$ 115,412		\$ 115,412	\$	\$ 4,004,636	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	\$ 1,854,022	\$ 80,736	\$ 80,736	\$		\$ 1,612,038	71
72	Current Year Purchases	76,491						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			13,026	13,026			74
75	TOTALS	\$ 1,930,513	\$ 80,736	\$ 93,762	\$ 13,026		\$ 1,612,038	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,648,125	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,148	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 209,174	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,026	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,616,674	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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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 \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ 75,809 Description: O2 Concentrators, Wheelchairs, Geri Chairs, elec. Beds, etc.

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		\$	\$ 46,191	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ 46,191	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/13 Ending: 05/31/14  
**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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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.)**

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
										visits	visits	
1	Licensed Occupational Therapist	10a	4465 hrs	\$ 180,557		\$	\$ 1,880	4,465	\$ 182,437	1		
2	Licensed Speech and Language Development Therapist	10a	3319 hrs	134,199			728	3,319	134,927	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a	6018 hrs	243,379			9,692	6,018	253,071	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 prescripts				837,388		837,388	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify): <u>Inhalation Therapist</u>				246	14,172		246	14,172	12		
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3				209,861	79,069		288,930	13		
14	<b>TOTAL</b>			\$ 558,135	246	\$ 224,033	\$ 928,757	14,048	\$ 1,710,925	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 of Champaign

# 0049395

Report Period Beginning: 06/01/13

Ending:

05/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 46	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (415,847) )	1,282,045		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,404		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,285,495	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,986		13
14	Buildings, at Historical Cost	4,413,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,930,513		16
17	Accumulated Depreciation (book methods)	(5,616,674)		17
18	Deferred Charges	1,905,647		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):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,937,098	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,222,593	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 152,062	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	361,782		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,812		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accrued Payables	141,730		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 716,386	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	802,268		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 802,268	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,518,654	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,703,939	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,222,593	\$	48

\*(See instructions.)



		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,068,137</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,068,137</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(909,092)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (909,092)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	544,894	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 544,894	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,703,939	<b>24</b> *

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

**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		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 9,410,715		1
2	Discounts and Allowances for all Levels	(5,112,518)		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,298,197		3
<b>B. Ancillary Revenue</b>				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	3,614,256		6
7	Oxygen			7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,614,256		8
<b>C. Other Operating Revenue</b>				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop	1,496		12
13	Barber and Beauty Care	6,358		13
14	Non-Patient Meals	22,608		14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	927,583		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory	289,053		19
20	Radiology and X-Ray	132,181		20
21	Other Medical Services	27,128		21
22	Laundry			22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,406,407		23
<b>D. Non-Operating Revenue</b>				
24	Contributions	100		24
25	Interest and Other Investment Income***			25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 100		26
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>			27
28	<u>Misc Income</u>	9,360		28
28a				28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,360		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,328,320		30

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,270,946		31
32	Health Care	4,132,538		32
33	General Administration	2,257,879		33
<b>B. Capital Expense</b>				
34	Ownership	1,208,666		34
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,191,548		35
36	Provider Participation Fee	175,835		36
<b>D. Other Expenses (specify):</b>				
37				37
38				38
39				39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,237,412		40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(909,092)		41
42	<b>Income Taxes</b>			42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (909,092)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 813,263	44
45	Private Pay - Net Inpatient Revenue	1,493,674	45
46	Medicare - Net Inpatient Revenue	1,529,435	46
47	Other-(specify) <u>Hospice</u>	66,709	47
48	Other-(specify) <u>Insurance</u>	395,116	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,298,197	49

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

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

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

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

Facility Name & ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	2,125	2,309	\$ 83,967	\$ 36.37	1
2	Assistant Director of Nursing	6,094	6,622	198,229	29.93	2
3	Registered Nurses	15,833	17,204	501,172	29.13	3
4	Licensed Practical Nurses	26,570	28,871	626,628	21.70	4
5	CNAs & Orderlies	68,545	74,636	951,242	12.75	5
6	CNA Trainees	257	279	3,053	10.94	6
7	Licensed Therapist	15,916	17,306	699,830	40.44	7
8	Rehab/Therapy Aides	15,749	17,124	452,288	26.41	8
9	Activity Director	3,568	3,881	49,967	12.87	9
10	Activity Assistants					10
11	Social Service Workers	7,274	7,911	142,451	18.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,927	8,638	100,732	11.66	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,240	52,626	23.49	17
18	Housekeepers	8,942	9,726	121,178	12.46	18
19	Laundry	3,772	4,102	48,669	11.86	19
20	Administrator	2,080	2,080	72,539	34.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,102	14,137	264,832	18.73	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	1,921	2,090	39,179	18.75	31
32	Other Health Care(specify)			53,961		32
33	Other(specify)	3,884	4,228		0.00	33
34	TOTAL (lines 1 - 33)	205,617	223,384	\$ 4,462,543 *	\$ 19.98	34

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

\*\* See instructions.

**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 20,847	9, 3	36
37	Medical Records Consultant	Monthly 2,425	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)	\$ 23,272		49

**C. CONTRACT NURSES**

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



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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Heartland of Champaign

# 0049395

Report Period Beginning:

06/01/13

Ending:

05/31/14

## 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 \$3,119
- (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 \$1447
- (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. \$ 41,083 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. \$ 175,835  
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. \$ 22,608
- (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.