FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049395

Facility Name: Heartland of Champaign

Address: 309 East Springfield (Number) | Champaign (City) | 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 352-5135 **Fax #** (217) 352-9139

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/14 to 05/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Martin Allen
(Title) Director, Reimbursement Services

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,790	6,927	15,678	30,395	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,790	6,927	15,678	30,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.64%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/81

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 102 and days of care provided 6,704

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Heartland of Champaign # 0049395 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,529	31,867	192,287	394,683		394,683		394,683			1
2	Food Purchase		305,705		305,705		305,705	(15,043)	290,662			2
3	Housekeeping	118,720	16,664	15,883	151,267		151,267		151,267			3
4	Laundry	54,404	18,624	12,894	85,922		85,922		85,922			4
5	Heat and Other Utilities			143,079	143,079	1,762	144,841		144,841			5
6	Maintenance	56,031	16,212	134,107	206,350		206,350		206,350			6
7	Other (specify):* **Med Waste**			729	729		729		729			7
8	**TOTAL General Services**	399,684	389,072	498,979	1,287,735	1,762	1,289,497	(15,043)	1,274,454			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,404,592	231,360	126,193	2,762,145	6,001	2,768,146		2,768,146			10
10a	Therapy	1,091,550	12,645	28,106	1,132,301		1,132,301		1,132,301			10a
11	Activities	58,351	6,389	320	65,060		65,060		65,060			11
12	Social Services	155,416	464	3,458	159,338		159,338		159,338			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,709,909	250,858	176,077	4,136,844	6,001	4,142,845		4,142,845			16
	C. General Administration											
17	Administrative			537,180	537,180	(170,093)	367,087		367,087			17
18	Directors Fees											18
19	Professional Services			32,287	32,287		32,287	(32,287)				19
20	Dues, Fees, Subscriptions & Promotions			116,410	116,410		116,410	(46,349)	70,061			20
21	Clerical & General Office Expenses	297,750	51,849	718,283	1,067,882		1,067,882	(658,560)	409,322			21
22	Employee Benefits & Payroll Taxes			710,084	710,084	32,618	742,702		742,702			22
23	Inservice Training & Education			282	282		282		282			23
24	Travel and Seminar			66,490	66,490		66,490		66,490			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			289,718	289,718		289,718		289,718			26
27	Other (specify):*											27
28	**TOTAL General Administration**	297,750	51,849	2,470,734	2,820,333	(137,475)	2,682,858	(737,196)	1,945,662			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,407,343	691,779	3,145,790	8,244,912	(129,712)	8,115,200	(752,239)	7,362,961			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland of Champaign #0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	6	7	8	9	10	
30	Depreciation			198,505	198,505	11,647	210,152		210,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			778,794	778,794	118,065	896,859	(793,261)	103,598			32
33	Real Estate Taxes			67,193	67,193		67,193		67,193			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			112,488	112,488		112,488		112,488			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,156,980	1,156,980	129,712	1,286,692	(793,261)	493,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		467,403		467,403		467,403		467,403			39
40	Barber and Beauty Shops			6,290	6,290		6,290		6,290			40
41	Coffee and Gift Shops	49,139			49,139		49,139		49,139			41
42	Provider Participation Fee			190,569	190,569		190,569		190,569			42
43	Other (specify):* **IV Therapy**		49,477	200,584	250,061		250,061		250,061			43
44	**TOTAL Special Cost Centers**	49,139	516,880	397,443	963,462		963,462		963,462			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,456,482	1,208,659	4,700,213	10,365,354		10,365,354	(1,545,500)	8,819,854			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: 06/01/14 Ending: 05/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,043)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(93)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(348)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,770)	21		18
19	Entertainment				19
20	Contributions	(1,600)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,790)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(632,728)	21		24
25	Fund Raising, Advertising and Promotional	(46,349)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5a	(817,779)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,545,500)		$	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))**	$ (1,545,500)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Heartland of Champaign

ID# **0049395**

Report Period Beginning: **06/01/14**

Ending: **05/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income	(1,493)	21	2
3	Vending Income	(1,528)	21	3
4	Accouning/Collection Fees	(21,497)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(793,261)	32	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	**Total**	(817,779)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Champaign **#** 0049395 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,043)	0	0	0	0	0	0	0	0	0	0	(15,043)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,043)	0	0	0	0	0	0	0	0	0	0	(15,043)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,287)	0	0	0	0	0	0	0	0	0	0	(32,287)	19
20	Fees, Subscriptions & Promotions	(46,349)	0	0	0	0	0	0	0	0	0	0	(46,349)	20
21	Clerical & General Office Expenses	(658,560)	0	0	0	0	0	0	0	0	0	0	(658,560)	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	**TOTAL General Administration**	(737,196)	0	0	0	0	0	0	0	0	0	0	(737,196)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(752,239)	0	0	0	0	0	0	0	0	0	0	(752,239)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Champaign # 0049395 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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

	Capital Expense D. Ownership	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)	
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	(793,261)	0	0	0	0	0	0	0	0	0	0	(793,261)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(793,261)	0	0	0	0	0	0	0	0	0	0	(793,261)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,545,500)	0	0	0	0	0	0	0	0	0	0	(1,545,500)	45

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 415,684	HCR Manor Care Services, LLC	100.00%	$ 415,684	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,456,482	Heartland Employment Services, LLC	100.00%	4,456,482		4
5	V	10a	Therapy Management	10,650	Heartland Rehabilitation Services, LLC	100.00%	10,650		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			$ 4,882,816			$ 4,882,816	$ *	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: 06/01/14 Ending: 05/31/15

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: 06/01/14 Ending: 05/31/15

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: HCR Manor Care Services LLC
Street Address: 333 North Summitt Street
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, &	$ 700,139	$	9,987,534	$ 1,762	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs			9,987,534	0	2
3	5	Utilities - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			9,987,534	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	365,628	262,581	9,987,534	920	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	9,987,534	5,081	5
6	10	Nursing - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			9,987,534	0	6
7	17	Gen & Admin - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	68,653,771	35,393,585	9,987,534	172,744	7
8	17	Gen & Admin - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	9,987,534	36,128	8
9	17	Gen & Admin-Direct to MW Div	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275		7,490,650	30,478	9
10	17	Gen & Admin - Direc toW Div SN	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860		2,496,883	6,241	10
11	22	Employee Ben - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	5,418,631		9,987,534	13,635	11
12	22	Employee Ben - Direct to SNFs	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		9,987,534	18,983	12
13	22	Employee Ben - Direct to W Div S	Accumulated Cost	346,847,752	45 NFs			9,987,534	0	13
14	30	Deprec - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	3,871,414		9,987,534	9,741	14
15	30	Deprec - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		9,987,534	1,906	15
16	30	Deprec - Direct to W Div SNFs	Accumulated Cost	346,847,752	45 NFs			9,987,534	0	16
17										17
18										18
19	32	Pooled Interest	Accumulated Cost	3,969,355,509		25,971,677		9,987,534	65,349	19
20	32	Directly Assigned Interest	Not Allocated			17,184,434			52,716	20
21										21
22	24	H/O costs Allocated to non-SNF & Other Divisions				33,870,689				22
23										23
24										24
25	TOTALS					$ 179,754,380	$ 39,285,837		$ 415,684	25

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub Debentures		X				$ 802,268	$ 802,268		0.0657	$ 52,716	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										65,349	7
8	Interest Expense / Interest Income										(14,467)	8
9	TOTAL Facility Related						$ 802,268	$ 802,268			$ 103,598	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 802,268	$ 802,268			$ 103,598	15

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

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

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 60,812	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 66,641	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,829	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,364	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 67,193	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	61,811	8
2011	62,362	9
2012	65,096	10
2013	66,340	11
2014	66,942	12

Line 2: $66,641.24 = $33,170.02 for 2nd half 2013 + $33,471.22 for 1st half 2014

Line 4: $61,363.72 = $33,471.22 for 2nd half 2014 + $27,892.50 for Jan - May 2015

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0049395

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	46-21-18-103-021	See Attached	$ 2,582.62	$ 2,582.62
2.	46-21-18-103-012	See Attached	$ 3,409.58	$ 3,409.58
3.	46-21-18-103-020	See Attached	$ 2,448.02	$ 2,448.02
4.	46-21-18-103-011	See Attached	$ 1,966.86	$ 1,966.86
5.	46-21-18-103-005	See Attached	$ 2,649.94	$ 2,649.94
6.	46-21-18-103-003	See Attached	$ 53,885.42	$ 53,885.42
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,942.44	$ 66,942.44

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 06/01/14 Ending: 05/31/15

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. [X] (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. [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).

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	Facility		1968	$ 54,050	1
2			2007	249,936	2
3	TOTALS			$ 303,986	3

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	102			1968	$ 1,201,229	$ (11,217)		$ (11,217)	$	$ 1,266,527	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Yerar Depreciation					99,882		99,882		2,826,774	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1987	(55,068)						13
14				1988	41,139						14
15				1989	1,297						15
16				1990	20,319						16
17				1991	50,575						17
18				1992	374,174						18
19	RETIREMENTS			1992	(6,784)						19
20				1993	51,354						20
21				1994	48,400						21
22				1995	229,982						22
23	ELECTRICAL WORK			1996	17,102						23
24	WALLVINYL			1996	10,548						24
25	VINYL FLOORING			1996	14,858						25
26	INSTALL CAMERA SYSTEM			1996	1,453						26
27	REMODEL 13 ROOMS AND LOBBY			1996	35,665						27
28	HVAC			1996	21,101						28
29	ROOF WORK			1996	1,365						29
30	CORPORATE OVERHEAD-13 ROOMS/LOBBY			1996	7,272						30
31	CONCRETE WORK			1996	3,880						31
32	CARPET			1996	5,900						32
33	DIGITAL KEYPAD			1996	1,915						33
34	INSTALL EMERGENCY GENERATOR			1996	44,791						34
35	INSTALL CIRCUIT BREAKER			1996	3,289						35
36	HVAC			1996	1,867						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	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		1998	500						69
70	TOTAL (lines 4 thru 69)		$ 2,355,636	$ 88,665		$ 88,665	$	$ 4,093,301	70

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 2,355,636	$ 88,665		$ 88,665	$	$ 4,093,301	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	TOTAL (lines 1 thru 33)		$ 2,521,510	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 2,521,510	$ 88,665		$ 88,665	$	$ 4,093,301	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	TOTAL (lines 1 thru 33)		$ 2,645,205	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 2,645,205	$ 88,665		$ 88,665	$	$ 4,093,301	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	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 2,882,610	$ 88,665		$ 88,665	$	$ 4,093,301	1
2	ELEVATORS - OVERHEAD AND INTEREST	2003	3,299						2
3	ELEVATORS CARPENTRY	2003	72,624						3
4	BORDERS	2003	127						4
5	VWC	2003	438						5
6	VWC	2003	4,080						6
7	VWC	2003	571						7
8	CARPET AND INSTALLATION	2003	4,190						8
9	SHOWER ROOM FLOORS AND WALLS	2003	6,901						9
10	SHOWER ROOM FLOORS AND WALLS	2003	289						10
11	DEVELOPERS COSTS - OVERHEAD	2004	17,971						11
12	DEVELOPERS COSTS - INTEREST	2004	1,099						12
13	CARPETING AND PADS	2004	7,249						13
14	WALLCOVERINGS	2004	46,392						14
15	EXTERIOR LIGHT POLE	2004	6,596						15
16	EXTERIOR LIGHT POLE	2004	687						16
17	CONCRETE SLAB	2005	3,115						17
18	VINYL WALL COVERING	2004	1,377						18
19	VINYL WALL COVERING AND PAINTING	2004	9,000						19
20	VINYL WALL COVERING	2004	938						20
21	VINYL WALL COVERING & PAINTING	2004	1,380						21
22	VINYL WALL COVERING & PAINTING	2004	3,420						22
23	COVE BASE	2004	2,160						23
24	DOORS	2004	5,893						24
25	CARPET	2004	4,275						25
26	INSTALL SECURITY DOOR	2005	2,910						26
27	FOURTEEN ARTWORK PIECES	2004	1,117						27
28	ELECTRICAL WORK	2005	5,926						28
29	STAIR TREDS	2005	5,640						29
30	OVERHEAD	2005	13,558						30
31	INTEREST	2005	805						31
32	FLOORING	2005	8,770						32
33	WALL COVERING	2005	8,050						33
34	TOTAL (lines 1 thru 33)		$ 3,133,457	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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 12E, Carried Forward		$ 3,133,457	$ 88,665		$ 88,665	$	$ 4,093,301	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	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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 12F, Carried Forward		$ 4,100,348	$ 88,665		$ 88,665	$	$ 4,093,301	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 F	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	BACK SERVICE ENT DOOR UPGRADES	2014	5,225						23
24	GEN ELEC UPGRADES	2014	13,450						24
25	ceiling repairs due to leak flrs 1, 2, & 3	2014	2,541						25
26	BOILER 500,000BTU	2014	20,516						26
27	7 top hats-library; fire caulking @ smoke barrier-visitors entr,								27
28	elev mech rm & by PT gym.	2015	6,600						28
29	BOILER BURNERS	2015	4,038						29
30	heat exchgr repl on 20 and 40 ton RTUs	2015	19,878						30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 4,485,875	$ 88,665		$ 88,665	$	$ 4,093,301	34

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	$ 1,930,513	$	$	$		$	71
72	Current Year Purchases	45,861	109,840	109,840			1,721,878	72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			11,647	11,647			74
75	TOTALS	$ 1,976,374	$ 109,840	$ 121,487	$ 11,647		$ 1,721,878	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)	$ 6,766,235	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 198,505	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,152	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,647	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,815,179	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.

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 65,542 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		$	$ 46,946	17
18					18
19					19
20					20
21	TOTAL		$	$ 46,946	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: 06/01/14 Ending: 05/31/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3510 hrs	$ 141,097		$	$ 283	3,510	$ 141,380	1
2	Licensed Speech and Language Development Therapist	10a	2604 hrs	104,679			1,126	2,604	105,805	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5930 hrs	238,363			11,236	5,930	249,599	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				467,403		467,403	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inalation Therapist	43, 2			371	21,815		371	21,815	12
13	Other (specify): EKG/X-Ray/Lab	43, 3				200,584	49,477		250,061	13
14	TOTAL			$ 484,139	371	$ 222,399	$ 529,525	12,415	$ 1,236,063	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/15 (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	$ 9,716	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (822,364))	1,250,249		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(2,608)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,257,357	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,986		13
14	Buildings, at Historical Cost	4,485,875		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,976,374		16
17	Accumulated Depreciation (book methods)	(5,815,179)		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 (spe OMIT	4,142		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,860,845	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,118,202	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,865	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	383,531		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,364		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	111,211		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 700,971	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	802,268		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)**	$ 802,268	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,503,239	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,614,963	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,118,202	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,703,939	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,703,939	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,390,949)	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)**	$ (1,390,949)	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	1,301,973	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,301,973	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,614,963	24	*

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	$ 9,072,658	1
2	Discounts and Allowances for all Levels	(5,171,906)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,900,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,735,492	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,735,492	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,528	12
13	Barber and Beauty Care	5,085	13
14	Non-Patient Meals	15,043	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	913,501	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	300,577	19
20	Radiology and X-Ray	66,234	20
21	Other Medical Services	34,607	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,336,575	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discount	1,586	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,586	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,974,405	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,287,735	31
32	Health Care	4,136,844	32
33	General Administration	2,820,333	33
	B. Capital Expense		
34	Ownership	1,156,980	34
	C. Ancillary Expense		
35	Special Cost Centers	772,893	35
36	Provider Participation Fee	190,569	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,365,354	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,390,949)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,390,949)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,110,608	44
45	Private Pay - Net Inpatient Revenue	1,797,893	45
46	Medicare - Net Inpatient Revenue	594,054	46
47	Other-(specify) Hospice	104,583	47
48	Other-(specify) Insurance	293,614	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,900,752	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: 06/01/14 Ending: 05/31/15

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	1,941	2,104	$ 91,992	$ 43.72	1
2	Assistant Director of Nursing	4,816	5,221	158,659	30.39	2
3	Registered Nurses	16,483	17,871	499,590	27.96	3
4	Licensed Practical Nurses	24,258	26,300	579,170	22.02	4
5	CNAs & Orderlies	76,454	82,973	1,038,019	12.51	5
6	CNA Trainees					6
7	Licensed Therapist	14,768	16,006	643,390	40.20	7
8	Rehab/Therapy Aides	15,455	16,750	448,160	26.76	8
9	Activity Director	3,896	4,228	58,351	13.80	9
10	Activity Assistants					10
11	Social Service Workers	6,825	7,411	155,416	20.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,477	13,554	170,529	12.58	15
16	Dishwashers					16
17	Maintenance Workers	2,138	2,321	56,031	24.14	17
18	Housekeepers	8,876	9,631	118,720	12.33	18
19	Laundry	4,359	4,731	54,404	11.50	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,832	14,701	297,750	20.25	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	1,817	1,972	37,162	18.84	31
32	Other Health Care(specify)					32
33	Other(specify) B&B	3,232	3,510	49,139	14.00	33
34	TOTAL (lines 1 - 33)	211,627	229,284	$ 4,456,482 *	$ 19.44	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9, 3	36
37	Medical Records Consultant	Monthly	7,806	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)		$ 25,806		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,829	$ 106,221	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,829	$ 106,221		53

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
N/A			
All Administrators thru Agency			
See Section B.			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 415,684
Purch Svc Admin for Clarence Boykin	10,962
Purch Svc Admin for David Lanza	4,190
Purch Svc Admin for Gina Graham	106,344
TOTAL (agree to Schedule V, line 17, col. 3)	$ 537,180
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Elvidge Kelley, Atty at Law	Legal Fees	$ 600
Greenberg Traurig	Legal Fees	4,515
Michael T Mahoney Ltd	Legal Fees	340
SNF Global	Legal Fees	5,335
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)		
Healthlink Inc	Collection Services	3,738
Medical Collection Group, LLC	Collection Services	850
Michael T Mahoney Ltd	Collection Services	8,940
Transworld Systems Inc	Collection Services	7,969
(Collection Costs were adjusted off via Page 5a, Line 6)		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 32,287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,913
Unemployment Compensation Insurance	63,144
FICA Taxes	319,899
Employee Health Insurance	261,217
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	9,716
Oth Empl Benefits & Marketing Adjustment	13,349
Tuition Reimbursement	10
SMSP Match	136
Employee Uniforms	10,700
Home Office Allocation	32,618
TOTAL (agree to Schedule V, line 22, col.8)	$ 742,702

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,106
Advertising: Employee Recruitment	34,559
Health Care Worker Background Check	
(Indicate # of checks performed 325)	6,866
Patient Background Checks 600	6,000
Dues & Subscriptions	15,885
Association Dues	5,826
Advertising	44,178
Other Licenses & Permits	1,990
Less: Non-allowable Assn. Dues	(2,171)
Less: Public Relations Expense	( )
Non-allowable advertising	(44,178)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,061

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	66,490
Includes travel expense to the Home Office	
in Toledo, OH for regional meetings.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 66,490

**See instructions.

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/14 Ending: 05/31/15

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 $3,655

(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_$2171

(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. $ 49,352 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. $ 190,569
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. $ 15,043

(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.