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: 0049544

Facility Name: Heartland of Decatur

Address: 444 West Harrison St (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 877-7333 **Fax #** (217) 872-6723

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

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

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 Decatur # 0049544 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	117	Skilled (SNF)	117	42,705	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	117	TOTALS	117	42,705	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,970	10,926	13,496	33,392	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,970	10,926	13,496	33,392	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.19%

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 117 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 Decatur # 0049544 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	133,097	21,300	156,958	311,355		311,355		311,355			1
2	Food Purchase		262,685		262,685		262,685	(1,215)	261,470			2
3	Housekeeping	163,555	22,412	25,659	211,626		211,626		211,626			3
4	Laundry	28,873	21,749	556	51,178		51,178		51,178			4
5	Heat and Other Utilities			152,975	152,975	1,725	154,700		154,700			5
6	Maintenance	46,878	27,224	118,999	193,101		193,101		193,101			6
7	Other (specify):* **Med Waste**			3,170	3,170		3,170		3,170			7
8	**TOTAL General Services**	372,403	355,370	458,317	1,186,090	1,725	1,187,815	(1,215)	1,186,600			8
	B. Health Care and Programs											
9	Medical Director			39,600	39,600		39,600		39,600			9
10	Nursing and Medical Records	2,669,220	225,898	194,402	3,089,520	5,877	3,095,397		3,095,397			10
10a	Therapy	817,236	12,694	167,182	997,112		997,112		997,112			10a
11	Activities	80,955	7,905	1,707	90,567		90,567	(123)	90,444			11
12	Social Services	78,222	1,841	3,419	83,482		83,482		83,482			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,645,633	248,338	406,310	4,300,281	5,877	4,306,158	(123)	4,306,035			16
	C. General Administration											
17	Administrative	103,928		403,935	507,863	(163,462)	344,401		344,401			17
18	Directors Fees											18
19	Professional Services			14,403	14,403		14,403	(14,403)				19
20	Dues, Fees, Subscriptions & Promotions			80,389	80,389		80,389	(30,643)	49,746			20
21	Clerical & General Office Expenses	374,980	45,821	446,717	867,518		867,518	(355,362)	512,156			21
22	Employee Benefits & Payroll Taxes			685,732	685,732	31,938	717,670		717,670			22
23	Inservice Training & Education			3,374	3,374		3,374		3,374			23
24	Travel and Seminar			8,077	8,077		8,077		8,077			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			193,688	193,688		193,688		193,688			26
27	Other (specify):*							(1,623)	(1,623)			27
28	**TOTAL General Administration**	478,908	45,821	1,836,315	2,361,044	(131,524)	2,229,520	(402,031)	1,827,489			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,496,944	649,529	2,700,942	7,847,415	(123,922)	7,723,493	(403,369)	7,320,124			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 Decatur #0049544 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			271,157	271,157	11,405	282,562		282,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,037,596	1,037,596	112,517	1,150,113	(1,050,309)	99,804			32
33	Real Estate Taxes			91,478	91,478		91,478		91,478			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			45,547	45,547		45,547		45,547			35
36	Other (specify):*											36
37	TOTAL Ownership			1,445,778	1,445,778	123,922	1,569,700	(1,050,309)	519,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		264,001	1,100	265,101		265,101		265,101			39
40	Barber and Beauty Shops			13,434	13,434		13,434		13,434			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,698	205,698		205,698		205,698			42
43	Other (specify):* IV Therapy		35,731	7,233	42,964		42,964		42,964			43
44	TOTAL Special Cost Centers		299,732	227,465	527,197		527,197		527,197			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,496,944	949,261	4,374,185	9,820,390		9,820,390	(1,453,678)	8,366,712			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 Decatur # 0049544 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	(1,215)	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	(135)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(421)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,623)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(36,550)	21		18
19	Entertainment				19
20	Contributions	(1,621)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,335)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(311,771)	21		24
25	Fund Raising, Advertising and Promotional	(30,643)	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	(1,064,364)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,453,678)		$	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))**	$ (1,453,678)		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

Heartland of Decatur

ID# 0049544

Report Period Beginning: 06/01/14

Ending: 05/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ (123)	11	1
2	Misc. Income	(3,150)	21	2
3	Vending Income	(1,714)	21	3
4	Accouning/Collection Fees	(9,068)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(1,050,309)	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**	(1,064,364)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Decatur **#** 0049544 **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 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,215)	0	0	0	0	0	0	0	0	0	0	(1,215)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,215)	0	0	0	0	0	0	0	0	0	0	(1,215)	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	(123)	0	0	0	0	0	0	0	0	0	0	(123)	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**	(123)	0	0	0	0	0	0	0	0	0	0	(123)	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	(14,403)	0	0	0	0	0	0	0	0	0	0	(14,403)	19
20	Fees, Subscriptions & Promotions	(30,643)	0	0	0	0	0	0	0	0	0	0	(30,643)	20
21	Clerical & General Office Expenses	(355,362)	0	0	0	0	0	0	0	0	0	0	(355,362)	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):*	(1,623)	0	0	0	0	0	0	0	0	0	0	(1,623)	27
28	**TOTAL General Administration**	(402,031)	0	0	0	0	0	0	0	0	0	0	(402,031)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(403,369)	0	0	0	0	0	0	0	0	0	0	(403,369)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Decatur # 0049544 **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	(1,050,309)	0	0	0	0	0	0	0	0	0	0	(1,050,309)	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**	(1,050,309)	0	0	0	0	0	0	0	0	0	0	(1,050,309)	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)**	(1,453,678)	0	0	0	0	0	0	0	0	0	0	(1,453,678)	45

Facility Name & ID Number Heartland of Decatur # 0049544 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	$ 403,935	HCR Manor Care Services, LLC	100.00%	$ 403,935	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,496,944	Heartland Employment Services, LLC	100.00%	4,496,944		4
5	V	10a	Therapy Management	12,216	Heartland Rehabilitation Services, LLC	100.00%	12,216		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			$ 4,913,095			$ 4,913,095	$ *	14

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

Facility Name & ID Number Heartland of Decatur # 0049544 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								1
2			Heartland of Canton IL, LLC	Canton				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 Decatur # 0049544 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			Heartland of Champaign IL, LLC	Champaign				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 Decatur # 0049544 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Heartland of Decatur # 0049544 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	$	9,779,430	$ 1,725	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs			9,779,430	0	2
3	5	Utilities - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			9,779,430	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	365,628	262,581	9,779,430	901	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	9,779,430	4,976	5
6	10	Nursing - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			9,779,430	0	6
7	17	Gen & Admin - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	68,653,771	35,393,585	9,779,430	169,145	7
8	17	Gen & Admin - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	9,779,430	35,374	8
9	17	Gen & Admin-Direct to MW Div	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275		7,334,573	29,843	9
10	17	Gen & Admin - Direc toW Div SN	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860		2,444,858	6,111	10
11	22	Employee Ben - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	5,418,631		9,779,430	13,350	11
12	22	Employee Ben - Direct to SNFs	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		9,779,430	18,588	12
13	22	Employee Ben - Direct to W Div S	Accumulated Cost	346,847,752	45 NFs			9,779,430	0	13
14	30	Deprec - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	3,871,414		9,779,430	9,538	14
15	30	Deprec - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		9,779,430	1,867	15
16	30	Deprec - Direct to W Div SNFs	Accumulated Cost	346,847,752	45 NFs			9,779,430	0	16
17										17
18										18
19	32	Pooled Interest	Accumulated Cost	3,969,355,509		25,971,677		9,779,430	63,987	19
20	32	Directly Assigned Interest	Not Allocated			17,184,434			48,530	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		$ 403,935	25

Facility Name & ID Number Heartland of Decatur # 0049544 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				$ 738,560	$ 738,560		0.0657	$ 48,530	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										63,987	7
8	Interest Expense / Interest Income										(12,713)	8
9	TOTAL Facility Related						$ 738,560	$ 738,560			$ 99,804	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 738,560	$ 738,560			$ 99,804	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 Decatur # 0049544 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.**	$	85,169	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.)	$	92,405	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,236	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	84,242	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.	$	91,478	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	96,143	8
2011	94,779	9
2012	94,925	10
2013	92,911	11
2014	91,876	12

Line 2: $92,405.13 = $46,455.55 for 2nd half 2013 + $45,919.58 for 1st half 2014

Line 4: $84,241.25 = $45,949.58 for 2nd half 2014 + $38,291.67 est. 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 Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0049544

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.	04-12-03-451-010	See Attached	$ 88,916.80	$ 88,916.80
2.	04-12-03-451-012	See Attached	$ 1,337.38	$ 1,337.38
3.	04-12-03-451-013	See Attached	$ 131.82	$ 131.82
4.	04-12-03-451-016	See Attached	$ 1,489.70	$ 1,489.70
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,875.70	$ 91,875.70

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 Decatur # 0049544 Report Period Beginning: 06/01/14 Ending: 05/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,542 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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		1981, 2005/06	$ 411,449	1
2			2009	45,126	2
3	TOTALS			$ 456,575	3

Facility Name & ID Number Heartland of Decatur # 0049544 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	84			1963	$ 659,655	$ 62,148		$ 62,148	$	$ 2,462,144	4
5	10			2002	480,558						5
6	23			2005	1,072,957						6
7	7/1/06 Capital Rate Adj #1			2005	259,992						7
8	Therapy Addition			2009	743,129						8
	Improvement Type**										
9	Current Yerar Depreciation					123,198		123,198		2,508,608	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15	RETIREMENTS			1987	(86,079)						15
16				1988	38,377						16
17				1989	18,196						17
18				1990	6,261						18
19				1991	162,665						19
20	RETIREMENTS			1991	(3,037)						20
21				1992	121,887						21
22	RETIREMENTS			1992	(6,084)						22
23				1993	191,712						23
24				1994	75,641						24
25	Consolidated 1995 Assets			1995	113,891						25
26	Consolidated1996 Assets			1996	49,186						26
27	Consolidated 1997 Assets			1997	69,918						27
28	Consolidated 1998 Assets			1998	168,373						28
29	Consolidated 1999 Assets			1999	34,171						29
30	Consolidated 2000 Assets			2000	122,059						30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Decatur # 0049544 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	B G ASSEMBLY	2001	$ 487	$		$	$	$	37
38	B G ASSEMBLY	2001	321						38
39	B G ASSEMBLY	2001	776						39
40	WATER HEATER	2001	8,452						40
41	WATER HEATER	2001	7,755						41
42	WATER HEATER - 2003 AUDIT ADJUSTMENT	2001	(500)						42
43	VINLY WALL COVERING	2001	434						43
44	AWNING	2001	2,013						44
45	VINLY WALL COVERING	2001	62						45
46	Border	2001	244						46
47	VWC	2001	316						47
48	Wall Coverings	2001	277						48
49	VWC	2001	200						49
50	Painting	2001	7,218						50
51	Window Treatments	2001	648						51
52	CARPET	2001	1,629						52
53	Light Fixtures	2001	3,404						53
54	Carpet	2001	870						54
55	Handrails	2001	1,865						55
56	Add'l Cost Smoke Shelter	2001	3,960						56
57	Smoke Shelter	2001	2,015						57
58	Painting	2001	7,200						58
59	Painting	2001	2,602						59
60	Add'l Cost Smoke Shelter	2001	600						60
61	Double Glass Doors	2001	4,050						61
62	Vinyl Tile & Sheets	2001	7,759						62
63	Wallpaper & Painting Retainage	2001	500						63
64	Wallpaper & Painting	2001	4,500						64
65	Doors	2001	4,935						65
66	Smoking Shelter	2001	5,400						66
67	VWC	2001	823						67
68	Smoke Shelter	2001	3,492						68
69	Artwork	2001	2,068						69
70	TOTAL (lines 4 thru 69)		$ 4,593,993	$ 185,346		$ 185,346	$	$ 4,970,752	70

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

Facility Name & ID Number Heartland of Decatur # 0049544 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		$ 4,593,993	$ 185,346		$ 185,346	$	$ 4,970,752	1
2	ARTWORK - 2003 AUDIT ADJUSTMENT	2001	(2,068)						2
3	Smoke Shelter	2001	388						3
4	Carpet	2001	8,821						4
5	Smoke Shelter	2001	400						5
6	Smoke Shelter	2001	988						6
7	Window treatments	2001	593						7
8	Kitchen store room door	2001	1,380						8
9	Sidewalk & Parking Lot	2001	8,555						9
10	Entrance Double Door	2001	1,305						10
11									11
12	Shower Room Renovation	2002	655						12
13	Window treatments	2002	3,459						13
14	Carpet and Installation	2002	1,190						14
15	Artwork	2002	2,199						15
16	ARTWORK - 2003 AUDIT ADJUSTMENT	2002	(2,199)						16
17	Renovation - OH & Int.	2002	1,905						17
18	RENOVATION-2003 AUDIT ADJUSTMENT	2002	(1,905)						18
19	Reno - Flooring, Painting	2002	29,775						19
20	Reno - Plumbing & Electrical	2002	37,536						20
21	Arch & Engineering Costs	2002	2,240						21
22	Arch & Engineering Costs	2002	619						22
23	Exterior Renovations - Soffitt & Gutters	2002	9,112						23
24	7/1/06 CAPITAL RATE ADJ #2	2002	(142)						24
25	Exterior Renovations - Soffitt & Gutters	2002	1,013						25
26	Vent Work	2002	331						26
27	Baseboard	2002	4,164						27
28	Adjust asset #1680 - (Reno-Plumbing & Electrical)	2002	(4,164)						28
29	Addtn. - Carpet, VWC & Sig	2002	9,213						29
30	Addtn - Concrete test & L	2002	3,599						30
31	Addtn - Permits	2002	8,834						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,721,789	$ 185,346		$ 185,346	$	$ 4,970,752	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 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		$ 4,721,789	$ 185,346		$ 185,346	$	$ 4,970,752	1
2	Renovation-Roofing & Sheet Metal	2003	67,148						2
3	Renovation-General Overhead	2003	1,031						3
4	7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						4
5	Renovation-Interest	2003	581						5
6	7/1/06 CAPITAL RATE ADJ #4	2003	(581)						6
7	AWNING	2003	2,470						7
8	Landscaping-Install Façade Materials	2003	23,984						8
9	GAZEBO	2003	6,215						9
10	ADD'L COST GAZEBO	2003	2,611						10
11	Renovation-Engineering	2004	4,880						11
12	Renovation-General Overhead	2004	10,453						12
13	7/1/06 Capital Rate Adj #5	2004	(10,453)						13
14	Renovation-Interest	2004	138						14
15	7/1/06 Capital Rate Adj #6	2004	(138)						15
16	Doors and Downspouts	2004	7,110						16
17	Doors Retainage	2004	790						17
18	Vinyl Tile and Cove Base	2004	17,910						18
19	Vinyl Tile and Base	2005	2,974						19
20	7/1/06 Capital Rate Adj #7	2005	(2,974)						20
21	Vinyl Tile	2005	2,974						21
22	7/1/06 Capital Rate Adj #7	2005	(2,974)						22
23	Vinyl Tile and Cove Base	2005	10,985						23
24	Water/Sewer/Utilities	2005	76,296						24
25	7/1/06 Capital Rate Adj #8	2005	(76,296)						25
26	Paving/Parking	2005	45,064						26
27	7/1/06 Capital Rate Adj #9	2005	(45,064)						27
28	Site Concrete	2005	20,963						28
29	7/1/06 Capital Rate Adj #10	2005	(20,963)						29
30	Site Preparation	2005	50,580						30
31	7/1/06 Capital Rate Adj #11	2005	(50,580)						31
32	Fencing/Gazebo/Courtyard	2005	13,234						32
33	7/1/06 Capital Rate Adj #12	2005	(13,234)						33
34	TOTAL (lines 1 thru 33)		$ 4,865,892	$ 185,346		$ 185,346	$	$ 4,970,752	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 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		$ 4,865,892	$ 185,346		$ 185,346	$	$ 4,970,752	1
2	Landscaping	2005	30,808						2
3	7/1/06 Capital Rate Adj #13	2005	(30,808)						3
4	Site Demolition	2005	25,400						4
5	7/1/06 Capital Rate Adj #17	2005	(25,400)						5
6	Water/Sewer Testing	2005	9,025						6
7	Landscaping	2005	10,269						7
8	7/1/06 Capital Rate Adj #14	2005	(10,269)						8
9	Landscaping	2005	1,838						9
10	7/1/06 Capital Rate Adj #15	2005	(1,838)						10
11	Nursing Station Carpentry	2005	3,360						11
12	Vinyl Wall Covering	2005	1,344						12
13	Architect & Engineering Fees	2005	150,302						13
14	7/1/06 Capital Rate Adj #18	2005	(13,833)						14
15	General Overhead & Interest	2005	221,331						15
16	7/1/06 Capital Rate Adj #19	2005	(221,331)						16
17	Permit Fees, Plan Reviews	2005	15,128						17
18	7/1/06 Capital Rate Adj #16	2005	(9,600)						18
19	Vinyl Wall Covering, Flooring	2005	34,342						19
20	Vinyl Wall Covering	2005	1,551						20
21	Carpet	2005	3,680						21
22	Canopy Sprinklers	2005	3,950						22
23	Blinds	2005	2,375						23
24	Vinyl Wall Covering	2005	(676)						24
25	Fabrics	2005	498						25
26	Flooring	2005	14,253						26
27	Overhead & Interest	2005	1,641						27
28	7/1/06 Capital Rate Adj #20	2005	(1,641)						28
29	Carpentry	2005	26,507						29
30	Doors	2006	624						30
31	HVAC	2006	5,715						31
32	Painting	2006	16,890						32
33	Rooftop Unit	2006	2,325						33
34	TOTAL (lines 1 thru 33)		$ 5,133,652	$ 185,346		$ 185,346	$	$ 4,970,752	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 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		$ 5,133,652	$ 185,346		$ 185,346	$	$ 4,970,752	1
2	Rooftop Unit	2006	10,910						2
3	Demolish & Reinstall Floors	2006	30,700						3
4	Ductwork	2006	1,163						4
5	Electrical	2006	4,176						5
6	Wallcovering, Painting	2006	2,187						6
7	Fence	2006	9,983						7
8	ENGINEERING FOR ENTRANCE	2007	1,425						8
9	EXTERIOR SIGN	2008	4,344						9
10	SEWER LINE	2008	707						10
11	SEWER LINE	2008	6,364						11
12	0407 RESI RM CORR OFFICE RENO	2008	7,619						12
13	0407 RESI RM CORR OFFICE RENO	2008	39,580						13
14	3 TON UNIT	2008	4,358						14
15	100 AMP PANEL	2008	1,986						15
16	ADJ HOT WATER SYS (ASSET 1903)	2008	7,947						16
17	1308 2 HOT WATER SYSTEM	2008	2,078						17
18	1308 2 HOT WATER SYSTEM	2008	302						18
19	1308 2 HOT WATER SYSTEM	2008	73,200						19
20	PT, BLD IM - ARCH, ENG & DEV COSTS	2009	120,617						20
21	PT, BLD IM - DEV GENL O-H	2009	54,958						21
22	PT, BLD IM - INT ON CONSTRUCTION	2009	13,277						22
23	PT, BLD IM - CARPET & PADS	2009	1,847						23
24	PT, BLD IM - WALL COVERINGS	2009	7,844						24
25	RETAINING WALL	2008	2,900						25
26	PAVING/SEALCOATING	2008	6,210						26
27	PT, LI - DEV COSTS	2009	44,176						27
28	PT, LI - GEN'L CONTRACTOR	2009	116,991						28
29	PT Addition - GEN'L CONTRACTOR	2009	13,771						29
30	PT Addition - Arch & Eng. Costs	2009	3,719						30
31	PT Addition - Wallcovering & Guards	2009	583						31
32	PT Addition - Electrical	2009	7,390						32
33	PT Addition - Arch & Eng. Costs	2009	962						33
34	TOTAL (lines 1 thru 33)		$ 5,737,926	$ 185,346		$ 185,346	$	$ 4,970,752	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 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		$ 5,737,926	$ 185,346		$ 185,346	$	$ 4,970,752	1
2	Fire proof Mechanical room ceiling	2010	8,881						2
3	Carpet (6 private rooms. 123, 152, 160-163)	2010	6,879						3
4	Wallcovering & Paint (Dining Rm, Main Shower, Resident Rms.)	2010	23,000						4
5	Heating element for roof top unit	2011	1,661						5
6	Replace 110 receptacles (electric outlets) in resident rooms	2011	6,050						6
7	Replace concrete walk in court yard	2011	4,230						7
8	Awning on front of building	2012	2,055						8
9									9
10	Metal Door	2012	2,715						10
11									11
12	Build closests/shelves in Dinning & Activities Rooms	2013	23,612						12
13	Doors(5) and Closers(15) for resident rooms	2013	23,194						13
14	Parking Addition, 18 spaces - Concrete	2013	94,060						14
15	Light fixture upgrade - whole building	2014	15,631						15
16	Pavilion Structure	2014	10,933						16
17	2 SINK PLUMBING for new kidney dialysis room	2013	6,455						17
18	85 Gal H/W Tank Upgrade	2014	15,767						18
19	85 Gal H/W Tank Upgrade	2014	13,835						19
20	install video intercom @ nurses stations 1 - 2, front, reception & arcadia doors.								20
21	Install securecare @ SVC corridor	2014	14,332						21
22	emergency pwr @ empl exit, sunnyside dining, patio gate, front/back nurses stations								22
23	back/front med rm, admin, PR, DON ofcs, & Phone rm	2015	18,356						23
24									24
25	PAINT-dining rm & res rm baths	2015	14,116						25
26	renov- painting, carpeting & pads, wallcovering in lobby/vestibule, front/back nurse's								26
27	stations, and all hallways throught bldg	2015	108,840						27
28	Data Drop	2015	1,157						28
29	renov -resilient flooring in lobby/vestibule, front/back nurse's								29
30	stations, and all hallways throught bldg	2015	137,286						30
31	repair collapsed sewer & water lines to bldg	2015	15,685						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,306,653	$ 185,346		$ 185,346	$	$ 4,970,752	34

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

Facility Name & ID Number Heartland of Decatur # 0049544 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	$ 1,970,311	$ 85,811	$ 85,811	$		$ 1,790,382	71
72	Current Year Purchases	83,969						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			11,405	11,405			74
75	TOTALS	$ 2,054,280	$ 85,811	$ 97,216	$ 11,405		$ 1,790,382	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)	$ 8,817,508	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 271,157	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 282,562	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,405	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,761,134	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 71,958	92
93			93
94			94
95		$ 71,958	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 Decatur # 0049544 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: $ 45,547 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Heartland of Decatur # 0049544 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 Decatur # 0049544 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	2078 hrs	$ 93,218	2,137	$ 138,286	$ 194	4,215	$ 231,698	1
2	Licensed Speech and Language Development Therapist	10a	1872 hrs	83,979			1,939	1,872	85,918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4718 hrs	211,647	8	512	10,561	4,726	222,720	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				264,001		264,001	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inalation Therapist	10a, 3 & 43, 2			412	26,681	35,731	412	62,412	12
13	Other (specify): IV Ther/X-Ray/Lab	43, 3				7,233			7,233	13
14	TOTAL			$ 388,844	2,557	$ 172,712	$ 312,426	11,225	$ 873,982	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 Decatur # 0049544 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	$ 19,271	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (555,400))	1,058,548		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,910		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,080,729	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,575		13
14	Buildings, at Historical Cost	6,306,653		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,054,280		16
17	Accumulated Depreciation (book methods)	(6,761,134)		17
18	Deferred Charges	6,363,068		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	13,160		22
23	Other(specify): CIP	71,958		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,504,560	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,585,289	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 148,993	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	352,040		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,241		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	94,996		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 680,270	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	738,560		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)**	$ 738,560	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,418,830	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,166,459	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,585,289	$	48

*(See instructions.)

Facility Name & ID Number Heartland of Decatur # 0049544 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**	$ 8,056,277	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,056,277	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,351,528)	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)**	$ (1,351,528)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	1,461,710	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,461,710	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,166,459	24 *

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

Facility Name & ID Number Heartland of Decatur # 0049544 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	$ 8,644,255	1
2	Discounts and Allowances for all Levels	(3,404,797)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,239,458	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,620,212	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,620,212	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	3,337	12
13	Barber and Beauty Care	8,160	13
14	Non-Patient Meals	1,215	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	522,183	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,891	19
20	Radiology and X-Ray		20
21	Other Medical Services	34,998	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 605,784	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	3,408	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,468,862	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,186,090	31
32	Health Care	4,300,281	32
33	General Administration	2,361,044	33
	B. Capital Expense		
34	Ownership	1,445,778	34
	C. Ancillary Expense		
35	Special Cost Centers	321,499	35
36	Provider Participation Fee	205,698	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,820,390	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,351,528)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,351,528)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,622,491	44
45	Private Pay - Net Inpatient Revenue	2,428,574	45
46	Medicare - Net Inpatient Revenue	890,337	46
47	Other-(specify) Hospice	86,145	47
48	Other-(specify) Insurance	211,911	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,239,458	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 Decatur # 0049544 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	2,108	2,254	$ 88,756	$ 39.38	1
2	Assistant Director of Nursing	5,546	5,931	173,601	29.27	2
3	Registered Nurses	16,146	17,267	499,553	28.93	3
4	Licensed Practical Nurses	30,963	33,112	730,499	22.06	4
5	CNAs & Orderlies	85,094	91,144	1,156,873	12.69	5
6	CNA Trainees	31	33	350	10.61	6
7	Licensed Therapist	11,083	11,841	531,132	44.86	7
8	Rehab/Therapy Aides	8,999	9,614	286,104	29.76	8
9	Activity Director	5,985	6,407	80,955	12.64	9
10	Activity Assistants					10
11	Social Service Workers	3,995	4,277	78,222	18.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,044	11,823	133,097	11.26	15
16	Dishwashers					16
17	Maintenance Workers	2,178	2,330	46,878	20.12	17
18	Housekeepers	13,701	14,663	163,555	11.15	18
19	Laundry	2,535	2,713	28,873	10.64	19
20	Administrator	2,080	2,080	103,928	49.97	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,652	18,918	374,980	19.82	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	1,333	1,428	19,588	13.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,473	235,835	$ 4,496,944 *	$ 19.07	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	39,600	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	219	11,081	10,1	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)	219	$ 50,681		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,332	$ 84,421	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,332	$ 84,421		53

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/14 Ending: 05/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Cassella	Administrator	0	$ 21,352
Gllenn Miller	Administrator	0	82,576
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,928

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 403,935
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 403,935

C. Professional Services

Vendor/Payee	Type	Amount
SNF Global	Legal Fees	$ 5,335
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)		
HealthLink	Collection Services	2,384
Medical Collection Group LLC	Collection Services	1,600
Michael T Mahoney LTD	Collection Services	3,530
Transworld Systems	Collection Services	1,553
(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)		$ 14,403

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,221
Unemployment Compensation Insurance	65,146
FICA Taxes	327,572
Employee Health Insurance	249,588
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	5,304
Oth Empl Benefits & Marketing Adjustment	8,414
Tuition Reimbursement	(100)
SMSP Match	131
Employee Uniforms	7,456
Home Office Allocation	31,938
TOTAL (agree to Schedule V, line 22, col.8)	$ 717,670

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	$ 1,184
Advertising: Employee Recruitment	26,208
Health Care Worker Background Check (Indicate # of checks performed 256)	6,218
Patient Background Checks 98	980
Dues & Subscriptions	9,075
Association Dues	6,516
Advertising	28,218
Other Licenses & Permits	1,990
Less: Non-allowable Assn. Dues	(2,425)
Less: Public Relations Expense	( )
Non-allowable advertising	(28,218)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,746

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,077
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)	$ 8,077

**See instructions.

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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 Decatur # 0049544 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 $2,465 & AHCA $1,626**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,243** 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. $ **205,698**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,215**

(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.