



Facility Name & ID Number Heartland of Decatur

# 0049544 Report Period Beginning: 06/01/12 Ending: 05/31/13

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,757	16,916	10,439	36,112	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,757	16,916	10,439	36,112	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.56%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 117 and days of care provided 8,966

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name &amp; ID Number

Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	247,325	33,314	82,714	363,353		363,353		363,353		1
2	Food Purchase		297,248		297,248		297,248	(98)	297,150		2
3	Housekeeping	159,406	26,713	51,041	237,160		237,160		237,160		3
4	Laundry	23,122	19,407		42,529		42,529		42,529		4
5	Heat and Other Utilities			174,717	174,717	1,866	176,583		176,583		5
6	Maintenance	46,622	18,016	83,493	148,131		148,131		148,131		6
7	Other (specify):* <b>Medical Waste</b>			4,353	4,353		4,353		4,353		7
8	<b>TOTAL General Services</b>	<b>476,475</b>	<b>394,698</b>	<b>396,318</b>	<b>1,267,491</b>	<b>1,866</b>	<b>1,269,357</b>	<b>(98)</b>	<b>1,269,259</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			43,200	43,200		43,200		43,200		9
10	Nursing and Medical Records	2,486,486	212,140	87,822	2,786,448	11,628	2,798,076		2,798,076		10
10a	Therapy	812,953	14,733	176,398	1,004,084		1,004,084		1,004,084		10a
11	Activities	85,131	16,539	2,087	103,757		103,757		103,757		11
12	Social Services	131,717	5,101	3,606	140,424		140,424		140,424		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,516,287</b>	<b>248,513</b>	<b>313,113</b>	<b>4,077,913</b>	<b>11,628</b>	<b>4,089,541</b>		<b>4,089,541</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	84,539		427,969	512,508	(175,479)	337,029		337,029		17
18	Directors Fees										18
19	Professional Services			10,507	10,507		10,507	(10,507)			19
20	Dues, Fees, Subscriptions & Promotions			62,106	62,106		62,106	(40,946)	21,160		20
21	Clerical & General Office Expenses	372,298	51,399	61,054	484,751		484,751	(69,350)	415,401		21
22	Employee Benefits & Payroll Taxes			734,199	734,199	36,015	770,214		770,214		22
23	Inservice Training & Education			5,986	5,986		5,986		5,986		23
24	Travel and Seminar			13,671	13,671		13,671		13,671		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			663,462	663,462		663,462		663,462		26
27	Other (specify):*							(964)	(964)		27
28	<b>TOTAL General Administration</b>	<b>456,837</b>	<b>51,399</b>	<b>1,978,954</b>	<b>2,487,190</b>	<b>(139,464)</b>	<b>2,347,726</b>	<b>(121,767)</b>	<b>2,225,959</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,449,599</b>	<b>694,610</b>	<b>2,688,385</b>	<b>7,832,594</b>	<b>(125,970)</b>	<b>7,706,624</b>	<b>(121,865)</b>	<b>7,584,759</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Heartland of Decatur

#0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			315,437	315,437	13,227	328,664		328,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,193,308	1,193,308	112,743	1,306,051	(1,203,865)	102,186			32
33	Real Estate Taxes			94,985	94,985		94,985		94,985			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,453	46,453		46,453		46,453			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,650,183	1,650,183	125,970	1,776,153	(1,203,865)	572,288			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		249,619	1,200	250,819		250,819		250,819			39
40	Barber and Beauty Shops			20,638	20,638		20,638		20,638			40
41	Coffee and Gift Shops	32,034			32,034		32,034		32,034			41
42	Provider Participation Fee			229,941	229,941		229,941		229,941			42
43	Other (specify):* <b>IV   X-Ray &amp; Lab</b>		46,207	3,487	49,694		49,694		49,694			43
44	<b>TOTAL Special Cost Centers</b>	32,034	295,826	255,266	583,126		583,126		583,126			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,481,633	990,436	4,593,834	10,065,903		10,065,903	(1,325,730)	8,740,173			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:

06/01/12

Ending:

05/31/13

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(98)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(689)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(964)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(715)	21		18
19	Entertainment				19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,110)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	11,750	21		24
25	Fund Raising, Advertising and Promotional	(40,946)	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	(1,284,908)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,325,730)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,325,730)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heartland of Decatur

ID# 0049544

Report Period Beginning: 06/01/12

Ending: 05/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Wage - Marketing	\$ (61,173)	21	1
2	Employee benefits - Marketing	(17,079)	21	2
3	HCP Lease Interest	(1,203,865)	32	3
4	Vending Income	(1,394)	21	4
5	Misc. Income	0	21	5
6	Activity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	36	7
8	Acct. Fees for Collections	(1,397)	19	8
9	Collection Agency Fees	0	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,284,908)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(98)	0	0	0	0	0	0	0	0	0	0	(98)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(98)</b>	<b>0</b>	<b>(98)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,507)	0	0	0	0	0	0	0	0	0	0	(10,507)	19
20	Fees, Subscriptions & Promotions	(40,946)	0	0	0	0	0	0	0	0	0	0	(40,946)	20
21	Clerical & General Office Expenses	(69,350)	0	0	0	0	0	0	0	0	0	0	(69,350)	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):*	(964)	0	0	0	0	0	0	0	0	0	0	(964)	27
28	<b>TOTAL General Administration</b>	<b>(121,767)</b>	<b>0</b>	<b>(121,767)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(121,865)</b>	<b>0</b>	<b>(121,865)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Decatur# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,203,865)	0	0	0	0	0	0	0	0	0	0	(1,203,865)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,203,865)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,203,865)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,325,730)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,325,730)</b>	<b>45</b>

**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.  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	\$ 427,969	HCR Manor Care Services, LLC	100.00%	\$ 427,969	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	4,481,633	Heartland Employment Services, LLC	100.00%	4,481,633		4
5	V	10a Therapy Management	13,598	Heartland Rehabilitation Services, LLC	100.00%	13,598		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		\$ 4,923,200			\$ 4,923,200	\$ *	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0	\$ *

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

Facility Name &amp; ID Number

Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of 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 (SNF), L	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 IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) 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:

06/01/12

Ending:

05/31/13

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 Decatur # 0049544 Report Period Beginning: 06/01/12 Ending: 05/31/13

## 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:

06/01/12

Ending: 05/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,R	\$ 748,673	\$ 9,968,361	\$ 1,866	1	
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs		9,968,361	0	2	
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs		9,968,361	0	3	
4									4	
5	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	419,407	305,829	9,968,361	1,045	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	9,968,361	10,583	6
7	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs		9,968,361	0	7	
8									8	
9	17	Gen/Admin-Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	66,682,648	33,182,703	9,968,361	166,199	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	9,968,361	50,946	10
11	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,307	9,968,361	35,345	11
12									12	
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	7,480,805		9,968,361	18,645	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	6,187,019		9,968,361	17,370	14
15	22	Empl Bnfts-Direct to MW Div SN	Accumulated Cost	517,936,312	48 NFs			9,968,361	0	15
16									16	
17	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	4,579,765		9,968,361	11,415	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474		9,968,361	1,812	18
19	30	Depr - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs			9,968,361	0	19
20									20	
21									21	
22	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		9,968,361	64,481	22
23	32	Directly Assigned Interest	Not Allocated			18,513,013			48,262	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				30,612,518				24
25	TOTALS					\$ 185,493,069	\$ 50,996,410	\$ 427,969	25	

Facility Name & ID Number

Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Conv. Sub. Debentures		X	Various			\$ 738,560	\$ 738,560		6.5346	\$ 48,262						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6	Home Office Pooled Interest Expense										64,481						
7	Interest Income / Interest Expense										(10,557)						
8																	
9	<b>TOTAL Facility Related</b>						\$ 738,560	\$ 738,560			\$ 102,186						
	<b>B. Non-Facility Related*</b>																
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 738,560	\$ 738,560			\$ 102,186						

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

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

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

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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2012 report.		\$ <b>86,119</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>94,853</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>8,734</b>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>86,251</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>94,985</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	<u>83,923</u>	8
	2009	<u>95,844</u>	9
	2010	<u>96,143</u>	10
	2011	<u>94,779</u>	11
	2012	<u>94,925</u>	12
<b>Line 2: \$94,853 = \$46,627 for the 2nd half of 2011 + 46,699 for the 1st half of 2012 + \$1,527 for the whole year of 2012.</b>			
<b>Line 4: \$86,251 = \$46,699 for the 2nd half 2012 + \$39,552 estimate for Jan-May 2013.</b>			
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Decatur COUNTY Macon  
 FACILITY IDPH LICENSE NUMBER 0049544  
 CONTACT PERSON REGARDING THIS REPORT Gary Geise  
 TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-12-03-451-013</u>	<u>See attached</u>	\$ <u>137.06</u>	\$ <u>137.06</u>
2. <u>04-12-03-451-012</u>	<u>See attached</u>	\$ <u>1,390.36</u>	\$ <u>1,390.36</u>
3. <u>04-12-03-451-016</u>	<u>See attached</u>	\$ <u>1,548.76</u>	\$ <u>1,548.76</u>
4. <u>04-12-03-451-010</u>	<u>See attached</u>	\$ <u>91,848.54</u>	\$ <u>91,848.54</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>94,924.72</u></u>	\$ <u><u>94,924.72</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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:

06/01/12 Ending:

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**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.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1981, 2005, 2006</u>	<u>\$ 411,449</u>	<u>1</u>
2			<u>2009</u>	<u>45,126</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 456,575</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	84		1963	\$ 659,655	\$ 62,921		\$ 62,921	\$ 2,337,074
5	10		2002	480,558				
6	23		2005	1,072,957				
7	7/1/06 Capital Rate Adj #1		2005	259,992				
8	Therapy addition		2009	743,129				
<b>Improvement Type**</b>								
9	Current Year Depreciation				161,578		161,578	2,278,644
10			1983	102,669				
11			1984	5,247				
12			1985	4,600				
13			1986	9,308				
14			1987	92,366				
15	RETIREMENTS		1987	(86,079)				
16			1988	38,377				
17			1989	18,196				
18			1990	6,261				
19			1991	162,665				
20	RETIREMENTS		1991	(3,037)				
21			1992	121,887				
22	RETIREMENTS		1992	(6,084)				
23			1993	191,712				
24			1994	75,641				
25			1995	47,351				
26	A/C WALL SLEEVE UNIT		1995	2,952				
27	INSTALL FIRE BOXES		1995	513				
28	ELECTRICAL		1995	7,058				
29	HANDRAILS		1995	8,442				
30	CONCRETE FLOOR		1995	884				
31	ARCHITECT-ARCADIA / LOBBY		1995	1,439				
32	LIGHTING		1995	4,074				
33	FLOORING		1995	2,080				
34	NURSE CALL SYSTEM		1995	38,400				
35	DOOR LOCKS		1995	698				
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 &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

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Ending:

05/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	UPGRADE ARCADIA / LOBBY	1996	\$ 10,460	\$		\$	\$	\$	37
38	WALL VINYL	1996	2,759						38
39	HANDRAILS	1996	9,792						39
40	CAPITALIZED LABOR-ARCADIA / LOBBY	1996	7,272						40
41	5/31/99 AUDIT ADJUSTMENT	1996	(7,272)						41
42	REMODELING-ARCADIA / LOBBY	1996	2,466						42
43	INSTALL FIRE DOORS	1996	8,340						43
44	PHONE WIRING/JACKS	1996	1,486						44
45	SIGNS/BOARDS	1996	952						45
46	A/C WORK	1996	3,237						46
47	ELECTRICAL-ARCADIA / LOBBY	1996	3,479						47
48	INSTALL TILES	1996	1,825						48
49	INSTALL ASPHALT	1996	4,390						49
50	WALL COVERINGS	1997	3,715						50
51	ROOFTOP TRANE UNITS	1997	12,448						51
52	INSTALL TILES/CEILING & WALLPANELS	1997	7,385						52
53	INSTALL WATER HEATER	1997	7,010						53
54	REPAIR ROOF LEAKS	1997	1,500						54
55	ELECTRICAL	1997	1,549						55
56	INSTALL DOORS	1997	12,737						56
57	WALL COVERINGS	1997	1,623						57
58	INSTALL VINYL TILE	1997	11,728						58
59	A/C COMPRESSOR WORK	1997	2,257						59
60	FACILITY PLAN ALLOC	1997	2,759						60
61	5/31/99 AUDIT ADJUSTMENT	1997	(2,759)						61
62	REPAIR WATER LEAKS	1997	1,408						62
63	NURSES STATION GATE	1997	625						63
64	LANDSCAPING	1997	828						64
65	SIDEWALK	1997	4,023						65
66	INSTALL PATIO COVERS	1997	1,082						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,183,015	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	70

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,183,015	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	<u>ROOFING</u>	1998	1,992						2
3	<u>HVAC</u>	1998	3,794						3
4	<u>TILE &amp; CARPET</u>	1998	6,771						4
5	<u>FINISH/STUD</u>	1998	3,333						5
6	<u>MASONRY WORK</u>	1998	1,333						6
7	<u>PLUMBING</u>	1998	3,172						7
8	<u>PAINTING/WALLCOVERINGS</u>	1998	2,182						8
9	<u>ELECTRICAL WORK</u>	1998	2,352						9
10	<u>CORPORATE OVERHEAD</u>	1998	1,702						10
11	<u>5/31/99 AUDIT ADJUSTMENT</u>	1998	(1,702)						11
12	<u>SECURITY SYSTEM</u>	1998	22,488						12
13	<u>IDPU PLAN REVIEW</u>	1998	1,362						13
14	<u>DOORS/WINDOWS</u>	1998	2,681						14
15	<u>GENERAL CONTRACTOR FEES</u>	1998	1,973						15
16	<u>FINISH/STUD</u>	1998	9,004						16
17	<u>MASONRY WORK</u>	1998	21,533						17
18	<u>FLOORING</u>	1998	5,943						18
19	<u>PAINTING/WALLCOVER</u>	1998	9,311						19
20	<u>PLUMBING</u>	1998	1,183						20
21	<u>ROOFING</u>	1998	41,500						21
22	<u>GENERAL CONTRACTORS FEES</u>	1998	4,278						22
23	<u>DOORS/WINDOWS</u>	1998	3,634						23
24	<u>ELECTRICAL</u>	1998	1,333						24
25	<u>HVAC</u>	1998	5,359						25
26	<u>SIGNAGE</u>	1998	11,862						26
27	<u>WALLCOVERING</u>	1999	18,122						27
28	<u>FLOORING</u>	1999	1,600						28
29	<u>WATER HEATER</u>	1999	1,089						29
30	<u>CARPET</u>	1999	2,769						30
31	<u>LEONARD MIXING VALVE</u>	1999	3,236						31
32	<u>FLOOR COVERING</u>	1999	1,552						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,379,756	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,379,756	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	FREIGHT CARPET TILES	1999	214						2
3	BUILDING DECORATIONS	1999	23						3
4	BATH STATION TRANSFORMER	1999	3,355						4
5	MJ ROST FREIGHT	1999	616						5
6	WALLCOVERING	1999	1,325						6
7	CORNERGUARD	1999	270						7
8	BOILER	2000	3,076						8
9	CONCRETE & CARPENTRY	2000	30,863						9
10	PAINTING	2000	49,231						10
11	PLUMBING	2000	14,039						11
12	PLUMBING-2003 AUDIT ADJUSTMENT	2000	(6,908)						12
13	DEVELOPERS COST-10 BED ADDTN	2000	116,845						13
14	DEVELOPERS COST-2003 AUDIT ADJUSTMENT	2000	(116,845)						14
15	ADDTL COST ON CONSTRUCTION-10 BED ADDTN	2000	1,938						15
16	CARPET INSTALLATION V#3504	2000	1,805						16
17	CEILING / FLOORING	2000	25,652						17
18	AWNING FRONT ENT / SERVICE ENT	2000	2,013						18
19	CLOSET DOOR	2000	350						19
20	B G ASSEMBLY	2001	487						20
21	B G ASSEMBLY	2001	321						21
22	B G ASSEMBLY	2001	776						22
23	WATER HEATER	2001	8,452						23
24	WATER HEATER	2001	7,755						24
25	WATER HEATER - 2003 AUDIT ADJUSTMENT	2001	(500)						25
26	VINLY WALL COVERING	2001	434						26
27	AWNING	2001	2,013						27
28	VINLY WALL COVERING	2001	62						28
29	Border	2001	244						29
30	VWC	2001	316						30
31	Wall Coverings	2001	277						31
32	VWC	2001	200						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,528,455	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,528,455	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	Painting	2001	7,218						2
3	Window Treatments	2001	648						3
4	CARPET	2001	1,629						4
5	Light Fixtures	2001	3,404						5
6	Carpet	2001	870						6
7	Handrails	2001	1,865						7
8	Add'l Cost Smoke Shelter	2001	3,960						8
9	Smoke Shelter	2001	2,015						9
10	Painting	2001	7,200						10
11	Painting	2001	2,602						11
12	Add'l Cost Smoke Shelter	2001	600						12
13	Double Glass Doors	2001	4,050						13
14	Vinyl Tile & Sheets	2001	7,759						14
15	Wallpaper & Painting Retainage	2001	500						15
16	Wallpaper & Painting	2001	4,500						16
17	Doors	2001	4,935						17
18	Smoking Shelter	2001	5,400						18
19	VWC	2001	823						19
20	Smoke Shelter	2001	3,492						20
21	Artwork	2001	2,068						21
22	ARTWORK - 2003 AUDIT ADJUSTMENT	2001	(2,068)						22
23	Smoke Shelter	2001	388						23
24	Carpet	2001	8,821						24
25	Smoke Shelter	2001	400						25
26	Smoke Shelter	2001	988						26
27	Window treatments	2001	593						27
28	Kitchen store room door	2001	1,380						28
29	Sidewalk & Parking Lot	2001	8,555						29
30	Entrance Double Door	2001	1,305						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,614,355	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,614,355	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	Shower Room Renovation	2002	655						2
3	Window treatments	2002	3,459						3
4	Carpet and Installation	2002	1,190						4
5	Artwork	2002	2,199						5
6	ARTWORK - 2003 AUDIT ADJUSTMENT	2002	(2,199)						6
7	Renovation - OH & Int.	2002	1,905						7
8	RENOVATION-2003 AUDIT ADJUSTMENT	2002	(1,905)						8
9	Reno - Flooring, Painting	2002	29,775						9
10	Reno - Plumbing & Electrical	2002	37,536						10
11	Arch & Engineering Costs	2002	2,240						11
12	Arch & Engineering Costs	2002	619						12
13	Exterior Renovations - Soffitt & Gutters	2002	9,112						13
14	7/1/06 CAPITAL RATE ADJ #2	2002	(142)						14
15	Exterior Renovations - Soffitt & Gutters	2002	1,013						15
16	Vent Work	2002	331						16
17	Baseboard	2002	4,164						17
18	Adjust asset #1680 - (Reno-Plumbing & Electrical)	2002	(4,164)						18
19	Addn. - Carpet, VWC & Sig	2002	9,213						19
20	Addn - Concrete test & L	2002	3,599						20
21	Addn - Permits	2002	8,834						21
22	Renovation-Roofing & Sheet Metal	2003	67,148						22
23	Renovation-General Overhead	2003	1,031						23
24	7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						24
25	Renovation-Interest	2003	581						25
26	7/1/06 CAPITAL RATE ADJ #4	2003	(581)						26
27	AWNING	2003	2,470						27
28	Landscaping-Install Façade Materials	2003	23,984						28
29	GAZEBO	2003	6,215						29
30	ADD'L COST GAZEBO	2003	2,611						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,824,217	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,824,217	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	Renovation-Engineering	2004	4,880						2
3	Renovation-General Overhead	2004	10,453						3
4	7/1/06 Capital Rate Adj #5	2004	(10,453)						4
5	Renovation-Interest	2004	138						5
6	7/1/06 Capital Rate Adj #6	2004	(138)						6
7	Doors and Downspouts	2004	7,110						7
8	Doors Retainage	2004	790						8
9	Vinyl Tile and Cove Base	2004	17,910						9
10	Vinyl Tile and Base	2005	2,974						10
11	7/1/06 Capital Rate Adj #7	2005	(2,974)						11
12	Vinyl Tile	2005	2,974						12
13	7/1/06 Capital Rate Adj #7	2005	(2,974)						13
14	Vinyl Tile and Cove Base	2005	10,985						14
15	Water/Sewer/Utilities	2005	76,296						15
16	7/1/06 Capital Rate Adj #8	2005	(76,296)						16
17	Paving/Parking	2005	45,064						17
18	7/1/06 Capital Rate Adj #9	2005	(45,064)						18
19	Site Concrete	2005	20,963						19
20	7/1/06 Capital Rate Adj #10	2005	(20,963)						20
21	Site Preparation	2005	50,580						21
22	7/1/06 Capital Rate Adj #11	2005	(50,580)						22
23	Fencing/Gazebo/Courtyard	2005	13,234						23
24	7/1/06 Capital Rate Adj #12	2005	(13,234)						24
25	Landscaping	2005	30,808						25
26	7/1/06 Capital Rate Adj #13	2005	(30,808)						26
27	Site Demolition	2005	25,400						27
28	7/1/06 Capital Rate Adj #17	2005	(25,400)						28
29	Water/Sewer Testing	2005	9,025						29
30	Landscaping	2005	10,269						30
31	7/1/06 Capital Rate Adj #14	2005	(10,269)						31
32	Landscaping	2005	1,838						32
33	7/1/06 Capital Rate Adj #15	2005	(1,838)						33
34	TOTAL (lines 1 thru 33)		\$ 4,874,917	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 4,874,917	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	Nursing Station Carpentry	2005	3,360						2
3	Vinyl Wall Covering	2005	1,344						3
4	Architect & Engineering Fees	2005	150,302						4
5	7/1/06 Capital Rate Adj #18	2005	(13,833)						5
6	General Overhead & Interest	2005	221,331						6
7	7/1/06 Capital Rate Adj #19	2005	(221,331)						7
8	Permit Fees, Plan Reviews	2005	15,128						8
9	7/1/06 Capital Rate Adj #16	2005	(9,600)						9
10	Vinyl Wall Covering, Flooring	2005	34,342						10
11	Vinyl Wall Covering	2005	1,551						11
12	Carpet	2005	3,680						12
13	Canopy Sprinklers	2005	3,950						13
14	Blinds	2005	2,375						14
15	Vinyl Wall Covering	2005	(676)						15
16	Fabrics	2005	498						16
17	Flooring	2005	14,253						17
18	Overhead & Interest	2005	1,641						18
19	7/1/06 Capital Rate Adj #20	2005	(1,641)						19
20	Carpentry	2005	26,507						20
21	Wallcovering	2006	624						21
22	Doors	2006	5,715						22
23	HVAC	2006	16,890						23
24	Painting	2006	2,325						24
25	Rooftop Unit	2006	10,910						25
26	Demolish & Reinstall Floors	2006	30,700						26
27	Ductwork	2006	1,163						27
28	Electrical	2006	4,176						28
29	Wallcovering, Painting	2006	2,187						29
30	Fence	2006	9,983						30
31	ENGINEERING FOR ENTRANCE	2007	1,425						31
32	EXTERIOR SIGN	2008	4,344						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,198,540	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,198,540	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	SEWER LINE	2008	707						2
3	SEWER LINE	2008	6,364						3
4	0407 RESI RM CORR OFFICE RENO	2008	7,619						4
5	0407 RESI RM CORR OFFICE RENO	2008	39,580						5
6	3 TON UNIT	2008	4,358						6
7	100 AMP PANEL	2008	1,986						7
8	ADJ HOT WATER SYS (ASSET 1903)	2008	7,947						8
9	1308 2 HOT WATER SYSTEM	2008	2,078						9
10	1308 2 HOT WATER SYSTEM	2008	302						10
11	1308 2 HOT WATER SYSTEM	2008	73,200						11
12	PT, BLD IM - ARCH, ENG & DEV COSTS	2009	120,617						12
13	PT, BLD IM - DEV GEN'L O-H	2009	54,958						13
14	PT, BLD IM - INT ON CONSTRUCTION	2009	13,277						14
15	PT, BLD IM - CARPET & PADS	2009	1,847						15
16	PT, BLD IM - WALL COVERINGS	2009	7,844						16
17	RETAINING WALL	2008	2,900						17
18	PAVING/SEALCOATING	2008	6,210						18
19	PT, LI - DEV COSTS	2009	44,176						19
20	PT, LI - GEN'L CONTRACTOR	2009	116,991						20
21									21
22	PT Addition - GEN'L CONTRACTOR	2009	13,771						22
23	PT Addition - Arch & Eng. Costs	2009	3,719						23
24	PT Addition - Wallcovering & Guards	2009	583						24
25	PT Addition - Electrical	2009	7,390						25
26	PT Addition - Arch & Eng. Costs	2009	962						26
27									27
28	Fire proof Mechanical room ceiling	2010	8,881						28
29	Carpet (6 private rooms. 123, 152, 160-163)	2010	6,879						29
30	Wallcovering & Paint (Dining Rm, Main Shower, Resident Rms.)	2010	23,000						30
31	Heating element for roof top unit	2011	1,661						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,778,347	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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	<b>Totals from Page 12H, Carried Forward</b>		\$ 5,778,347	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	1
2	Replace 110 receptacles (electric outlets) in resident rooms	2011	6,050						2
3	Replace concrete walk in court yard	2011	4,230						3
4	Awning on front of building	2012	2,055						4
5									5
6	Metal Door	2012	2,715						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,793,397	\$ 224,499		\$ 224,499	\$	\$ 4,615,718	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,872,911	\$ 90,938	\$ 90,938	\$		\$ 1,617,568	71
72	Current Year Purchases	39,503						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			13,227	13,227			74
75	TOTALS	\$ 1,912,414	\$ 90,938	\$ 104,165	\$ 13,227		\$ 1,617,568	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)		\$ 8,162,386	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 315,437	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 328,664	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 13,227	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 6,233,286	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	Various	\$ 7,015	92
93			93
94			94
95		\$ 7,015	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: 06/01/12

Ending: 05/31/13

**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

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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 46,453 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: 06/01/12 Ending: 05/31/13  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a, 1	1324	hrs	\$ 57,732	2,004	\$ 128,675	\$ 119	3,328	\$ 186,526	1
2	Licensed Speech and Language Development Therapist	10a, 1	4195	hrs	182,868			1,188	4,195	184,056	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	4919	hrs	214,361			13,426	4,919	227,787	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				249,619		249,619	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						46,207		46,207	12
13	Other (specify): <u>X-Ray &amp; Lab</u>	43, 3					3,487			3,487	13
14	<b>TOTAL</b>				\$ 454,961	2,004	\$ 132,162	\$ 310,559	12,442	\$ 897,682	14

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

Facility Name & ID Number Heartland of Decatur# 0049544Report Period Beginning: 06/01/12

Ending:

05/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/13

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (4,915)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>232,040</u> )	1,103,700		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(835)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,097,950	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,575		13
14	Buildings, at Historical Cost	5,793,397		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,912,414		16
17	Accumulated Depreciation (book methods)	(6,233,286)		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 (specify):			22
23	Other(specify): <u>CIP</u>	7,015		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 8,299,183	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 9,397,133	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 90,063	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	357,516		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,251		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payables</u>	120,740		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 654,570	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	738,560		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 738,560	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,393,130	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 8,004,003	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 9,397,133	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,202,717	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,202,717	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(895,217)	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)	\$ (895,217)	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	696,503	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 696,503	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,004,003	24 *

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

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

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

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 9,297,018	1	
2	Discounts and Allowances for all Levels	(2,812,903)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,484,115	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,182,354	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,182,354	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	1,394	12	
13	Barber and Beauty Care	18,323	13	
14	Non-Patient Meals	98	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	378,660	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	40,098	19	
20	Radiology and X-Ray	23,369	20	
21	Other Medical Services	42,225	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 504,167	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions	50	24	
25	Interest and Other Investment Income***		25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 50	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Activity Income</b>		28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,170,686	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,267,491	31	
32	Health Care	4,077,913	32	
33	General Administration	2,487,190	33	
<b>B. Capital Expense</b>				
34	Ownership	1,650,183	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	353,185	35	
36	Provider Participation Fee	229,941	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,065,903	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(895,217)	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (895,217)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 956,122	44
45	Private Pay - Net Inpatient Revenue	3,384,426	45
46	Medicare - Net Inpatient Revenue	1,922,159	46
47	Other-(specify) <u>HOSP</u>		47
48	Other-(specify) <u>INSURANCE</u>	221,408	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,484,115	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:

06/01/12

Ending:

05/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,085	2,274	\$ 82,813	\$ 36.42	1
2	Assistant Director of Nursing	5,616	6,122	178,730	29.19	2
3	Registered Nurses	13,413	14,622	396,550	27.12	3
4	Licensed Practical Nurses	31,065	33,867	694,479	20.51	4
5	CNAs & Orderlies	82,800	90,454	1,113,116	12.31	5
6	CNA Trainees					6
7	Licensed Therapist	10,438	11,374	495,777	43.59	7
8	Rehab/Therapy Aides	10,024	10,923	317,176	29.04	8
9	Activity Director	6,593	7,192	85,131	11.84	9
10	Activity Assistants					10
11	Social Service Workers	5,901	6,439	131,717	20.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,973	22,890	247,325	10.80	15
16	Dishwashers					16
17	Maintenance Workers	2,160	2,357	46,622	19.78	17
18	Housekeepers	13,654	14,899	159,406	10.70	18
19	Laundry	1,988	2,172	23,122	10.65	19
20	Administrator	2,080	2,080	84,539	40.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,112	15,387	294,046	19.11	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	1,451	1,583	20,798	13.14	31
32	Other Health Care(specify)					32
33	Other(specify)	2,349	2,565	32,034	12.49	33
34	TOTAL (lines 1 - 33)	226,702	247,200	\$ 4,403,381 *	\$ 17.81	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	43,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	198	10,139	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)	198	\$ 53,339		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	220	\$ 7,365	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides			10, 3	52
53	TOTAL (lines 50 - 52)	220	\$ 7,365		53



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

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

Facility Name &amp; ID Number Heartland of Decatur

# 0049544

Report Period Beginning:

06/01/12

Ending:

05/31/13

## 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. IHCA \$3088
- (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. \$ 63,130 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. \$ 229,941  
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. \$ 98
- (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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.