

Facility Name & ID Number Heartland of Galesburg

0049460 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	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	84	TOTALS	84	30,660	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	10,350	6,222	7,879	24,451	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,350	6,222	7,879	24,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.75%

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 84 and days of care provided 3,812

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

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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
	A. General Services										
1	Dietary	39,802	17,642	184,533	241,977		241,977	241,977			1
2	Food Purchase		180,748		180,748		180,748	(18,531)	162,217		2
3	Housekeeping	149,524	19,703	582	169,809		169,809		169,809		3
4	Laundry	16,403	14,578		30,981		30,981		30,981		4
5	Heat and Other Utilities			146,610	146,610	945	147,555		147,555		5
6	Maintenance	43,175	9,098	79,681	131,954		131,954		131,954		6
7	Other (specify):* Medical Waste			575	575		575		575		7
8	TOTAL General Services	248,904	241,769	411,981	902,654	945	903,599	(18,531)	885,068		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	1,396,950	151,708	40,078	1,588,736	3,218	1,591,954		1,591,954		10
10a	Therapy	492,993	4,387	16,144	513,524		513,524		513,524		10a
11	Activities	39,129	7,581	2,740	49,450		49,450		49,450		11
12	Social Services	115,354		1,594	116,948		116,948		116,948		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,044,426	163,676	82,156	2,290,258	3,218	2,293,476		2,293,476		16
	C. General Administration										
17	Administrative	88,551		258,039	346,590	(126,322)	220,268		220,268		17
18	Directors Fees										18
19	Professional Services			25,286	25,286		25,286	(25,286)			19
20	Dues, Fees, Subscriptions & Promotions			56,073	56,073		56,073	(40,664)	15,409		20
21	Clerical & General Office Expenses	204,034	34,583	50,770	289,387		289,387	6,574	295,961		21
22	Employee Benefits & Payroll Taxes			431,378	431,378	17,493	448,871		448,871		22
23	Inservice Training & Education			557	557		557		557		23
24	Travel and Seminar			8,371	8,371		8,371		8,371		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			22,897	22,897		22,897		22,897		26
27	Other (specify):*										27
28	TOTAL General Administration	292,585	34,583	853,371	1,180,539	(108,829)	1,071,710	(59,376)	1,012,334		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,585,915	440,028	1,347,508	4,373,451	(104,666)	4,268,785	(77,907)	4,190,878		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.

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	
	D. Ownership											
30	Depreciation			202,289	202,289	6,248	208,537		208,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			378,392	378,392	98,418	476,810	(383,528)	93,282			32
33	Real Estate Taxes			151,750	151,750		151,750		151,750			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,332	49,332		49,332		49,332			35
36	Other (specify):*											36
37	TOTAL Ownership			781,763	781,763	104,666	886,429	(383,528)	502,901			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,573		230,573		230,573		230,573			39
40	Barber and Beauty Shops			6,675	6,675		6,675		6,675			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,873	165,873		165,873		165,873			42
43	Other (specify):* IV X-Ray & Lab		48,419	37,634	86,053		86,053		86,053			43
44	TOTAL Special Cost Centers		278,992	210,182	489,174		489,174		489,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,585,915	719,020	2,339,453	5,644,388		5,644,388	(461,435)	5,182,953			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 Galesburg

0049460

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	(18,531)	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	(55)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(998)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,996)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	9,132	21		24
25	Fund Raising, Advertising and Promotional	(40,664)	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	(387,323)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (461,435)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (461,435)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	HCP Lease Interest	\$ (383,528)	32	1
2	Vending Income	(1,505)	21	2
3	Misc. Income		21	3
4	Activity Income		11	4
5	Loss on Disposal of Fixed Assets		36	5
6	Acct. Fees for Collections	(2,290)	19	6
7	Collection Agency Fees		19	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		(387,323)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(18,531)	0	0	0	0	0	0	0	0	0	0	(18,531)	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	(18,531)	0	(18,531)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,286)	0	0	0	0	0	0	0	0	0	0	(25,286)	19
20	Fees, Subscriptions & Promotions	(40,664)	0	0	0	0	0	0	0	0	0	0	(40,664)	20
21	Clerical & General Office Expenses	6,574	0	0	0	0	0	0	0	0	0	0	6,574	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(59,376)	0	(59,376)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,907)	0	(77,907)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Galesburg# 0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(383,528)	0	0	0	0	0	0	0	0	0	0	(383,528)	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	(383,528)	0	0	0	0	0	0	0	0	0	0	(383,528)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(461,435)	0	0	0	0	0	0	0	0	0	0	(461,435)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	home office
				HL Empl Svcs, LLC	Toledo	personnel
				HL Rehab Svcs, LLC	Toledo	therapy mgmt svcs
				HL Rehab Svcs, LLC	Toledo	therapy services
				HL Home Health Care	Toledo	nursing staff

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See						1
2	V	Page 8						2
3	V							3
4	V	1-44						4
5	V	10a						5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,852,915			\$ 2,852,915	\$ *	14

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

Facility Name & ID Number

Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4								4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Manor Care of Wilmette IL, LLC	Wilmette				29
30			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				30

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0049460

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Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 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 Galesburg

0049460

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	\$ 700,139	\$ 5,356,613	\$ 945	1	
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs		5,356,613	0	2	
3	5	Utilities - Direct to Western Divisi	Accumulated Cost	346,847,752	45 NFs		5,356,613	0	3	
4									4	
5	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	365,628	262,581	5,356,613	493	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	5,356,613	2,725	6
7	10	Nursing - Direct to Western Divisi	Accumulated Cost	346,847,752	45 NFs			5,356,613	0	7
8									8	
9	17	General & Administrative - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	68,653,771	35,393,585	5,356,613	92,648	9
10	17	General & Administrative - Direc	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	5,356,613	19,376	10
11	17	General & Administrative - Direc	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275		4,017,460	16,346	11
12	17	General & Administrative - Direc	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860		1,339,153	3,347	12
13									13	
14	22	Employee Benefits - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	5,418,631		5,356,613	7,312	14
15	22	Employee Benefits - Direct to All	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		5,356,613	10,181	15
16	22	Employee Benefits - Direct to Wes	Accumulated Cost	346,847,752	45 NFs			5,356,613	0	16
17									17	
18	30	Depreciation - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	3,871,414		5,356,613	5,226	18
19	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		5,356,613	1,022	19
20	30	Depreciation - Direct to Western	Accumulated Cost	346,847,752	45 NFs			5,356,613	0	20
21									21	
22	32	Pooled Interest	Accumulated Cost	3,969,355,509		25,971,677		5,356,613	35,049	22
23	32	Directly Assigned Interest	Not Allocated			17,184,434			63,369	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				33,870,689				24
25	TOTALS					\$ 179,754,380	\$ 39,285,838	\$ 258,039	25	

Facility Name & ID Number

Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Conv. Sub. Debentures		X	Various			\$ 964,387	\$ 964,387		6.5709	\$ 63,369						
2																	
3																	
4																	
5																	
	Working Capital																
6	Home Office Pooled Interest Expense										35,049						
7	Interest Income / Interest Expense										(5,136)						
8																	
9	TOTAL Facility Related						\$ 964,387	\$ 964,387			\$ 93,282						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 964,387	\$ 964,387			\$ 93,282						

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2013 report.		\$	140,433		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.)		\$	146,092		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	5,658		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	146,092		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.		\$	151,750		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	81,933	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2010	82,799	9												
	2011	83,972	10												
	2012	140,433	11												
	2013	146,092	12												
Line 2-1st half 2013 is \$73,045.83 & 2nd half 2013 is \$73,045.83.															

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049460

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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>99-10-427-018</u>	<u>See attached</u>	\$ <u>73,045.83</u>	\$ <u>73,045.83</u>
2.	<u>99-10-427-018</u>	<u>See attached</u>	\$ <u>73,045.83</u>	\$ <u>73,045.83</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>146,091.66</u></u>	\$ <u><u>146,091.66</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heartland of Galesburg

0049460 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,388 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).

N/A

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>1983 & 2003</u>	<u>\$ 121,935</u>	1
2	<u>Facility</u>		<u>2006</u>	<u>47,025</u>	2
3	TOTALS			\$ 168,960	3

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	69	1964	1964	\$ 407,801	\$ 35,390		\$ 35,390	\$	\$ 757,598
5	7		2003	570,110					
6	7/1/06 Capital Rate Adj #1		2003	81,936					
7	8		2005	637,826					
8	7/1/06 Capital Rate Adj #14		2005	125,742					
Improvement Type**									
9	Building Improvements (Current Year Depreciation)				103,469		103,469		2,081,735
10	Building Improvements		1968	73					
11	Building Improvements		1969	1,059					
12	Building Improvements		1970	1,083					
13	Building Improvements		1971	10,602					
14	Building Improvements		1972	5,946					
15	Building Improvements		1973	758					
16	Building Improvements		1974	817					
17	Building Improvements		1975	3,645					
18	Building Improvements		1978	19,333					
19	Land Improvements		1983	1,350					
20	Building Improvements		1984	21,913					
21	Building Improvements		1985	42,479					
22	Land Improvements		1985	8,457					
23	Building Improvements		1986	23,347					
24	Land Improvements		1986	2,349					
25	Building Improvements		1987	19,172					
26	Building Improvements		1988	14,265					
27	Land Improvements		1988	1,470					
28	Building Improvements		1989	36,615					
29	Land Improvements		1990	1,500					
30	Building Improvements		1990	27,793					
31	Building Improvements		1991	9,501					
32	Building Improvements		1992	24,536					
33	Building Improvements		1993	16,600					
34	Land Improvements		1994	3,095					
35	Building Improvements		1994	1,278					
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 Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Land Improvements	1995	\$ 1,098	\$		\$	\$	\$	37
38	Building Improvements	1995	14,214						38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693						39
40	engineering fees, demolition, masonry, concrete, drywall,								40
41	windows, doors, wood trim, paint, counter tops, electrical								41
42	Building Improvements : Wallcovering	1996	79,684						42
43	Building Improvements : Carpet and vinyl	1996	33,131						43
44	Building Improvements : Ceramic flooring	1996	40,886						44
45	Building Improvements : Millwork	1996	25,990						45
46	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45 (1996)	1996	(627)						46
47	Building Improvements : Electrical lighting, plumbing fixtures, ha	1996	51,580						47
48	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								48
49	vinyl flooring								49
50	Building Improvements : Doors	1997	10,728						50
51	Building Improvements : Electrical composite, automatic doors,	1997	38,947						51
52	metal doors, fire alarm system								52
53	Building Improvements : Capalo	1997	2,500						53
54	Building Improvements : Generator	1997	7,743						54
55	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						55
56	Building Improvements : Onan Genator	1997	17,482						56
57	Building Improvements : Soffits, gutters & trim	1997	9,962						57
58	Building Improvements : Generator	1997	24,885						58
59	Building Improvements - HVAC	1997	42,499						59
60	Land Improvements - Sidewald	1998	7,988						60
61	Building Improvements - Fire Prevention System	1998	35,013						61
62	Sidewalk	1999	7,988						62
63	Sidewalk	1999	900						63
64	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	1999	(900)						64
65	Overhead from const	1999	2,681						65
66	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	1999	(2,681)						66
67	Power control wiring for ne	1999	2,392						67
68	Sprinkler system upgrade	1999	19,107						68
69	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	1999	(1,740)						69
70	TOTAL (lines 4 thru 69)		\$ 3,084,150	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	70

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,084,150	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	Air compressor	1999	598						2
3	Laundry room floor	1999	1,800						3
4	Sprinkler upgrade	1999	23,940						4
5	Fire sprinkler system	1999	2,971						5
6	Boiler	1999	33,600						6
7	HVAC upgrade	1999	2,420						7
8	Building improvements	1999	1,200						8
9	SMOKING HUT	2000	4,950						9
10	CONCRETE FOR SMOKE HUT	2000	350						10
11	CABINETRY	2000	3,690						11
12	ELECTRICAL	2000	20,205						12
13	ADDT'L COST SMOKING HUT	2000	645						13
14	ELECTRICAL	2000	10,880						14
15	ELECTRICAL	2000	3,454						15
16	HVAC	2000	21,662						16
17	ELECTRICAL/NEW OFFICE	2000	860						17
18	CABINETS	2000	1,369						18
19	HVAC	2000	1,736						19
20	HVAC	2000	193						20
21	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						21
22	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2000	(15,146)						22
23	AIR / HUMIDIFIER COIL	2001	5,233						23
24	CANOPY	2001	1,200						24
25	CONCRETE PATIO	2001	5,500						25
26	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						26
27	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2001	(6,839)						27
28	VWC	2002	1,172						28
29	Carpet	2002	1,534						29
30	Border	2002	111						30
31	Border	2002	125						31
32	Brick Work	2002	5,787						32
33	Addition Cost Brick Work	2002	643						33
34	TOTAL (lines 1 thru 33)		\$ 3,333,631	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	34

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,333,631	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	Artwork	2002	2,219						2
3	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2002	(2,219)						3
4	Paint & Wallcovering	2002	2,810						4
5	Paint & Wallcovering	2002	3,122						5
6	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						6
7	Overhead & Interest	2003	431						7
8	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)						8
9	Paint, Flooring & VWC	2003	12,182						9
10	Paint, Flooring & VWC	2003	1,354						10
11	Freight on Carpet	2003	56						11
12	Carpet, Wallcovering and Corner Guards	2003	12,197						12
13	Developers Costs - Architect & Engineering Fees	2003	96,312						13
14	7/1/06 Capital Rate Adj #4	2003	(10,839)						14
15	7/1/06 Capital Rate Adj #5	2003	(17,967)						15
16	Developers Costs - T&E, Reprod., Permit & Plan Review Fees	2003	15,798						16
17	7/1/06 Capital Rate Adj #6	2003	(5,436)						17
18	Developers Costs - Overhead	2003	152,775						18
19	7/1/06 Capital Rate Adj #7	2003	(152,775)						19
20	Developers Costs - Interest	2003	13,748						20
21	7/1/06 Capital Rate Adj #8	2003	(13,748)						21
22	Millwork	2003	4,664						22
23	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						23
24	7/1/06 Capital Rate Adj #2	2003	(6,851)						24
25	Site Work/Preparation	2003	74,492						25
26	7/1/06 Capital Rate Adj #3	2003	(74,492)						26
27	CONSULTING SERVICES-PHASE 2 ADDITION	2003	3,200						27
28	ARCHITECTURAL SERVICES	2003	9,117						28
29	ENGINEERING COST-CENTRAL BATH RENOV	2004	4,013						29
30	ENGINEERING COST-CENTRAL BATH RENOV	2004	6,479						30
31	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	723						31
32	ARCHITECTURAL COST-CENTRAL BATH RENOV	2004	180						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,506,529	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	34

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,506,529	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	ENGINEERING COST-CENTRAL BATH RENOV	2004	450						2
3	VINYL WALL COVERING	2004	266						3
4	BORDER	2004	948						4
5	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	2,986						5
6	BORDER FOR BATH	2004	85						6
7	ENGINEERING COST-CENTRAL BATH RENOV	2004	2,794						7
8	CARPET & COVE BASE	2004	6,273						8
9	VINYL WALL COVERING	2004	8,199						9
10	GAZEBO	2004	6,389						10
11	MATERIAL & SVCS-NURSING STA & BATH	2004	93,206						11
12	VINYL WALL COVERING	2005	497						12
13	GENERAL CONTRACTOR	2005	117,042						13
14	7/1/06 Capital Rate Adj #9	2005	(117,042)						14
15	SOIL TESTING	2005	1,790						15
16	7/1/06 Capital Rate Adj #10	2005	(1,790)						16
17	GAS SERVICE	2005	321						17
18	7/1/06 Capital Rate Adj #11	2005	(321)						18
19	SOIL TESTING	2005	3,370						19
20	7/1/06 Capital Rate Adj #12	2005	(3,370)						20
21	CONCRETE TESTING	2005	2,555						21
22	7/1/06 Capital Rate Adj #13	2005	(2,555)						22
23	GENERAL OVERHEAD	2005	8,273						23
24	7/1/06 Capital Rate Adj #15	2005	(8,273)						24
25	INTEREST ON CONSTRUCTION	2005	426						25
26	7/1/06 Capital Rate Adj #16	2005	(426)						26
27	CARPETING & PADS	2005	708						27
28	WALL COVERING	2005	4,135						28
29	CARPENTRY	2005	68,875						29
30	DRYWALL/STUDS	2005	1,500						30
31	DOORS/FRAMES	2005	1,125						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,704,964	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	34

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,704,964	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	ARCHITECT & ENGINEER COST	2005	59,040						2
3	ARCHITECT & ENGINEER COST	2005	8,988						3
4	ENGINEERING - CIVIL	2005	9,080						4
5	ENGINEERING - ELECTRIC	2005	600						5
6	LANDSCAPE DESIGN CONTRACTOR	2005	12,705						6
7	OVERHEAD	2005	106,428						7
8	7/1/06 Capital Rate Adj #18	2005	(106,428)						8
9	PERMIT FEES	2005	2,825						9
10	PLAN REVIEWS	2005	8,271						10
11	7/1/06 Capital Rate Adj #19	2005	(8,271)						11
12	INTEREST ON CONSTRUCTION	2005	16,467						12
13	7/1/06 Capital Rate Adj #20	2005	(16,467)						13
14	CARPETING AND PADS	2005	2,835						14
15	WALL COVERING	2005	9,095						15
16	CORNER GUARDS	2006	225						16
17	FIRE PROTECTION PIPING	2006	600						17
18	BASIC ELECTRICAL	2006	490						18
19	WALLCOVERINGS	2006	1,215						19
20	3 SETS OF DOORS	2006	4,226						20
21	INSTALL GUTTERS/WINDOWS	2006	14,500						21
22	VINYL WALL COVERING	2006	150						22
23	GUTTERS	2006	2,025						23
24	FLOORING-KITCHEN STORAGE	2006	6,278						24
25	EXPAND FREEZER & COOLER	2006	30,957						25
26	DOOR	2006	3,041						26
27	SIDEWALKS	2007	6,879						27
28	SIDEWALKS	2007	2,106						28
29	boiler room door	2007	2,419						29
30	Fire Sprinkler System	2007	2,728						30
31	Architecture for Concrete	2007	1,739						31
32	LAUNDRY RM IMP-DRYWALL, PAINT & DOORS	2007	11,516						32
33	DOOR LEADING TO KITCHEN	2007	2,127						33
34	TOTAL (lines 1 thru 33)		\$ 3,903,353	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	34

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,903,353	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	0707 NURSE STATION GEN'L OH	2007	631						2
3	0707 NURSE STATION CARPENTRY	2007	16,655						3
4	0707 NURSE STATION CABINETS	2007	12,567						4
5	HOT WATER HEATER	2008	11,677						5
6	new garage	2008	10,325						6
7	PT DOUBLE DOORS	2008	4,750						7
8	OT DOUBLE DOORS	2008	4,750						8
9	NEW GARAGE	2008	10,325						9
10	garage work	2008	1,950						10
11	Door Replacement / Renovation	2008	2,157						11
12									12
13	Concrete Ramp	2008	10,800						13
14	HVAC Controls	2009	2,540						14
15	HVAC Controls	2009	39,798						15
16									16
17	BI 040685 Kithen door	2010	2,470						17
18	BI 040686 front enterance awning	2010	3,198						18
19	BI 040688 adj asset 40686-frnt ent awning	2010	3,198						19
20	BI 040689 VCT flooring	2010	13,925						20
21	BI 040690 add'l cost VCT flooring	2010	13,925						21
22									22
23	BI 040701 Water Heater	2011	13,500						23
24	BI 040702 acoustical ceiling	2011	7,200						24
25	BI 040703 STAINLESS STEEL BACKSLACH	2011	7,650						25
26	BI 040704 CEILING GRID IN DINING RM	2011	3,285						26
27									27
28	000000040712 WALL COVERING & CARPET in Front Corridor	2012	23,432						28
29	000000040720 BURNER ASSEMBLY FOR BOILER	2012	8,515						29
30	000000040721 WALLCOVERING in Front Corridor	2012	934						30
31	000000040722 FIRE DOOR In TV Lounge	2012	3,105						31
32	000000040723 WALLCOVERING in Front Corridor	2012	848						32
33	000000040724 WALL COVERING & CARPET-Front Corridor	2012	2,604						33
34	TOTAL (lines 1 thru 33)		\$ 4,140,065	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	34

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,140,065	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	1
2	000000040725 WALLCOVERING IN FRONT CORRIDOR	2012	3,713						2
3	000000040726 WALLCOVERING IN FRONT CORRIDOR	2012	609						3
4	000000040730 CONCRETE Front Bldg & SEAL COAT Parking Lot	2012	6,388						4
5	000000040738 Install WATER HEATER/rep HEAT Exchanger in boiler	2013	23,852						5
6	000000040747LIGHTING UPGRADES	2014	7,027						6
7	000000040761 Shower stall repairs-installed new tile	2014	2,650						7
8	000000040762 Shower stall repairs-install flooring	2014	2,565						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	TOTAL (lines 1 thru 33)		\$ 4,186,870	\$ 138,859		\$ 138,859	\$	\$ 2,839,333	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	\$ 1,760,538	\$ 63,430	\$ 63,430	\$		\$ 1,642,274	71
72	Current Year Purchases	52,641						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			6,248	6,248			74
75	TOTALS	\$ 1,813,179	\$ 63,430	\$ 69,678	\$ 6,248		\$ 1,642,274	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,169,009	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,289	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,537	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,248	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,481,607	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ 23,502 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	<u>Patient Transportation</u>	<u>2013 Ford Van E350</u>	\$ <u>#####</u>	\$ <u>25,830</u>	17
18					18
19				<u>above figure includes</u>	19
20				<u>gas & maintenance too</u>	20
21	TOTAL		\$ <u>#####</u>	\$ <u>25,830</u>	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 Galesburg # 0049460 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	1454	hrs	\$ 63,568		\$ 305	1,454	\$ 63,873	1	
2	Licensed Speech and Language Development Therapist	10a	581	hrs	25,422		193	581	25,615	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	10a	1652	hrs	72,225		3,889	1,652	76,114	4	
5	Physician Care			visits						5	
6	Dental Care			visits						6	
7	Work Related Program			hrs						7	
8	Habilitation			hrs						8	
9	Pharmacy	39, 2		# of prescripts			230,573		230,573	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					48,419		48,419	12	
13	Other (specify): <u>X-Ray & Lab</u>	43, 3				37,634			37,634	13	
14	TOTAL				\$ 161,215		\$ 37,634	\$ 283,379	3,687	\$ 482,228	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 Galesburg# 0049460Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,657	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>67,174</u>)	793,359		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 800,016	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,960		13
14	Buildings, at Historical Cost	4,186,870		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,813,180		16
17	Accumulated Depreciation (book methods)	(4,481,605)		17
18	Deferred Charges	726,205		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>OMIT</u>)			22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,413,610	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,213,626	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,873	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	222,226		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	146,092		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	73,004		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 509,195	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	964,387		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)	\$ 964,387	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,473,582	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,740,044	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,213,626	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,787,083	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,787,083	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	232,340	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)	\$ 232,340	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(279,379)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (279,379)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,740,044	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		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 5,836,720	1	
2	Discounts and Allowances for all Levels	(2,283,270)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,553,450	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,571,007	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,571,007	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	1,505	12	
13	Barber and Beauty Care	7,718	13	
14	Non-Patient Meals	16,704	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	464,615	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	130,515	19	
20	Radiology and X-Ray	68,897	20	
21	Other Medical Services	62,317	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 752,271	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	Activity Income & Misc.		28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,876,728	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	902,654	31	
32	Health Care	2,290,258	32	
33	General Administration	1,180,539	33	
B. Capital Expense				
34	Ownership	781,763	34	
C. Ancillary Expense				
35	Special Cost Centers	323,301	35	
36	Provider Participation Fee	165,873	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,644,388	40	
41	Income before Income Taxes (line 30 minus line 40)**	232,340	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 232,340	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,459,530	44
45	Private Pay - Net Inpatient Revenue	1,242,378	45
46	Medicare - Net Inpatient Revenue	358,436	46
47	Other-(specify) <u>Hospice</u>	46,092	47
48	Other-(specify) <u>Insurance</u>	447,014	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,553,450	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 Galesburg

0049460

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,096	2,281	\$ 79,445	\$ 34.83	1
2	Assistant Director of Nursing	4,140	4,505	113,779	25.26	2
3	Registered Nurses	7,942	8,642	213,769	24.74	3
4	Licensed Practical Nurses	19,115	20,799	369,619	17.77	4
5	CNAs & Orderlies	49,567	54,102	588,694	10.88	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	6,135	6,673	291,778	43.73	7
8	Rehab/Therapy Aides	5,754	6,258	201,215	32.15	8
9	Activity Director	1,842	2,007	39,129	19.50	9
10	Activity Assistants					10
11	Social Service Workers	5,648	6,154	115,354	18.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,247	3,532	39,802	11.27	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,092	43,175	20.64	17
18	Housekeepers	13,365	14,563	149,524	10.27	18
19	Laundry	1,546	1,688	16,403	9.72	19
20	Administrator	2,080	2,080	88,551	42.57	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,162	8,932	204,034	22.84	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	2,198	2,396	31,644	13.21	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0			33
34	TOTAL (lines 1 - 33)	134,757	146,704	\$ 2,585,915 *	\$ 17.63	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	21,600	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,600		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Heartland of Galesburg

0049460

Report Period Beginning:

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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 \$1699 & AHCA \$1169
- (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. \$ 38,233 Line 10, 2
- (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. \$ 165,873
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. \$ 18,531
- (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.