

Facility Name & ID Number Heartland of Macomb

0049585 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	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	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	11,000	6,522	6,348	23,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,000	6,522	6,348	23,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.75%

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 04/01/1989

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 80 and days of care provided 4,217

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL 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.

Facility Name & ID Number

Heartland of Macomb

0049585

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	44,747	28,992	152,952	226,691		226,691	226,691			1
2	Food Purchase		186,285		186,285		186,285	(24,411)	161,874		2
3	Housekeeping	98,317	15,417	706	114,440		114,440		114,440		3
4	Laundry	17,579	19,709	302	37,590		37,590		37,590		4
5	Heat and Other Utilities			104,740	104,740	992	105,732		105,732		5
6	Maintenance	42,815	17,842	90,869	151,526		151,526		151,526		6
7	Other (specify):* Medical Waste			585	585		585		585		7
8	TOTAL General Services	203,458	268,245	350,154	821,857	992	822,849	(24,411)	798,438		8
	B. Health Care and Programs										
9	Medical Director			3,090	3,090		3,090		3,090		9
10	Nursing and Medical Records	1,447,389	134,045	26,581	1,608,015	3,379	1,611,394		1,611,394		10
10a	Therapy	573,750	4,744	23,413	601,907		601,907		601,907		10a
11	Activities	52,086	5,232	2,462	59,780		59,780		59,780		11
12	Social Services	84,455	32	1,798	86,285		86,285		86,285		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,157,680	144,053	57,344	2,359,077	3,379	2,362,456		2,362,456		16
	C. General Administration										
17	Administrative	80,133		242,578	322,711	(104,294)	218,417		218,417		17
18	Directors Fees										18
19	Professional Services			13,599	13,599	(475)	13,124	(13,124)			19
20	Dues, Fees, Subscriptions & Promotions			92,940	92,940		92,940	(73,768)	19,172		20
21	Clerical & General Office Expenses	179,132	44,695	88,596	312,423	475	312,898	(51,958)	260,940		21
22	Employee Benefits & Payroll Taxes			488,123	488,123	18,366	506,489		506,489		22
23	Inservice Training & Education			1,287	1,287		1,287		1,287		23
24	Travel and Seminar			16,044	16,044		16,044		16,044		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,017	113,017		113,017		113,017		26
27	Other (specify):*							(451)	(451)		27
28	TOTAL General Administration	259,265	44,695	1,056,184	1,360,144	(85,928)	1,274,216	(139,301)	1,134,915		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,620,403	456,993	1,463,682	4,541,078	(81,557)	4,459,521	(163,712)	4,295,809		29

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

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

Facility Name & ID Number

Heartland of Macomb

#0049585

Report Period Beginning:

01/01/14

Ending:

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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			182,999	182,999	6,558	189,557		189,557			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			551,628	551,628	74,999	626,627	(556,438)	70,189			32
33	Real Estate Taxes			60,976	60,976		60,976		60,976			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,591	46,591		46,591		46,591			35
36	Other (specify):*											36
37	TOTAL Ownership			842,194	842,194	81,557	923,751	(556,438)	367,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,218	140	127,358		127,358		127,358			39
40	Barber and Beauty Shops		68	8,925	8,993		8,993		8,993			40
41	Coffee and Gift Shops	45,071			45,071		45,071		45,071			41
42	Provider Participation Fee			163,670	163,670		163,670		163,670			42
43	Other (specify):* IV X-Ray & Lab		25,644	68,249	93,893		93,893		93,893			43
44	TOTAL Special Cost Centers	45,071	152,930	240,984	438,985		438,985		438,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,665,474	609,923	2,546,860	5,822,257		5,822,257	(720,150)	5,102,107			45

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

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0049585

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,411)	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	(252)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(451)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,012)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,918)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,106)	21		24
25	Fund Raising, Advertising and Promotional	(73,768)	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 See Attached Page 5A	(560,232)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (720,150)		\$	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))	\$ (720,150)		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

Heartland of Macomb

ID# 0049585

Report Period Beginning: 01/01/14

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ (556,438)	32	1
2	Vending Income	(588)	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	(3,206)	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		(560,232)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Macomb# 0049585

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24,411)	0	0	0	0	0	0	0	0	0	0	(24,411)	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	(24,411)	0	0	0	0	0	0	0	0	0	0	(24,411)	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	(13,124)	0	0	0	0	0	0	0	0	0	0	(13,124)	19
20	Fees, Subscriptions & Promotions	(73,768)	0	0	0	0	0	0	0	0	0	0	(73,768)	20
21	Clerical & General Office Expenses	(51,958)	0	0	0	0	0	0	0	0	0	0	(51,958)	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):*	(451)	0	0	0	0	0	0	0	0	0	0	(451)	27
28	TOTAL General Administration	(139,301)	0	0	0	0	0	0	0	0	0	0	(139,301)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(163,712)	0	0	0	0	0	0	0	0	0	0	(163,712)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Macomb

0049585

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	(556,438)	0	0	0	0	0	0	0	0	0	0	(556,438)	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	(556,438)	0	0	0	0	0	0	0	0	0	0	(556,438)	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)	(720,150)	0	0	0	0	0	0	0	0	0	0	(720,150)	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: 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		
1	V	See Home Office Allocation	\$ 242,578	HCR Manor Care Services, LLC	100.00%	\$ 242,578	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	2,665,474	Heartland Employment Services, LLC	100.00%	2,665,474		4
5	V	10a Therapy Management	8,535	Heartland Rehabilitation Services, LLC	100.00%	8,535		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		\$ 2,916,587			\$ 2,916,587	\$ *	14

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

Facility Name & ID Number

Heartland of Macomb

0049585

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			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6								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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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

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Macomb

0049585

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	\$ 0	5,623,646	\$ 992	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs		0	5,623,646	0	2
3	5	Utilities - Direct to Western Divisi	Accumulated Cost	346,847,752	45 NFs		0	5,623,646	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	365,628	262,581	5,623,646	518	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	5,623,646	2,861	6
7	10	Nursing - Direct to Western Divisi	Accumulated Cost	346,847,752	45 NFs			5,623,646	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	5,623,646	97,267	9
10	17	General & Administrative - Direc	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	5,623,646	20,342	10
11	17	General & Administrative - Direc	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275	0	4,217,734	17,161	11
12	17	General & Administrative - Direc	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860	0	1,405,911	3,514	12
13										13
14	22	Employee Benefits - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	5,418,631		5,623,646	7,677	14
15	22	Employee Benefits - Direct to All	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		5,623,646	10,689	15
16	22	Employee Benefits - Direct to Wes	Accumulated Cost	346,847,752	45 NFs			5,623,646	0	16
17										17
18	30	Depreciation - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	3,871,414		5,623,646	5,485	18
19	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		5,623,646	1,073	19
20	30	Depreciation - Direct to Western	Accumulated Cost	346,847,752	45 NFs			5,623,646	0	20
21										21
22	32	Pooled Interest	Accumulated Cost			25,971,677		5,623,646	36,796	22
23	32	Directly Assigned Interest	Not Allocated			17,184,434			38,203	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				33,870,689				24
25	TOTALS					\$ 179,754,380	\$ 39,285,838		\$ 242,578	25

Facility Name & ID Number

Heartland of Macomb

0049585

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			\$ 581,402	\$ 581,402		6.5708	\$ 38,203	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Home Office Pooled Interest Expense										36,796	6					
7	Interest Income / Interest Expense										(4,810)	7					
8												8					
9	TOTAL Facility Related						\$ 581,402	\$ 581,402			\$ 70,189	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 581,402	\$ 581,402			\$ 70,189	15					

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

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

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

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.		\$	59,343		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.)		\$	60,159		2
3. Under or (over) accrual (line 2 minus line 1).		\$	817		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,159		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.		\$	60,976		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	56,019	8	FOR BHF USE ONLY	
	2010	57,095	9		
	2011	57,405	10	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2012	59,343	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	60,159	12	15	LESS REFUND FROM LINE 6 \$ 15
Line 2 - 1st half 2013 (\$30,079.63) & 2nd half 2013 (\$30,079.63)				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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0049585

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-300-953-00</u>	<u>See attached</u>	\$ <u>58,930.54</u>	\$ <u>58,930.54</u>
2. <u>11-300-961-00</u>	<u>See attached</u>	\$ <u>1,228.72</u>	\$ <u>1,228.72</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>60,159.26</u></u>	\$ <u><u>60,159.26</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 Macomb

0049585 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,692 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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	Facility		1983	\$ 57,104	1
2	Facility		2003	49,141	2
3	TOTALS			\$ 106,245	3

Facility Name & ID Number Heartland of Macomb

0049585

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	Accumulated Depreciation
4	58		1983	\$ 824,586	\$ 28,317		\$ 28,317	\$ 1,151,349
5	6		2001	404,817				
6	Audit adj 7/1/03(#1)		2001	(55,875)				
7	16		2003	726,962				
8	Audit adj 7/1/06 (#17)		2003	56,765				
Improvement Type**								
9	Current Year Depreciation				106,902		106,902	1,797,748
10	Building Improvements (Current Year Depreciation)		1983	19,035				
11	Land Improvements		1983	300				
12	Land Improvements - Audit Adj 7/1/03 (#7) - Chg Yr		1984	15,076				
13	Building Improvements		1985	20,813				
14	Building Improvements		1986	42,783				
15	Building Improvements		1986	3,741				
16	Land Improvements		1986	(60,000)				
17	Adjust HGCC Purchase		1986	60,000				
18	Audit Adj 7/1/03 (#2) - Pg 12, Line 16		1987	70,097				
19	Building Improvements		1987	490				
20	Interior Renovation		1987	(490)				
21	Audit Adj 7/1/03 (#8) - Pg 12, Line19		1988	2,068				
22	Building Improvements		1988	732				
23	Water Heater		1988	(732)				
24	Audit Adj 7/1/03 (#3) - Pg 12 Line 22		1988	1,336				
25	Repair Valve		1988	(1,336)				
26	Audit Adj 7/1/03 (#4) - Pg 12 Line 24		1988	3,770				
27	Light Fix-Over Bed		1988	(3,770)				
28	Audit Adj 7/1/03 (#5) - Pg 12 Line 26		1989	1,614				
29	Land Improvements		1989	25,315				
30	Building Improvements		1990	4,980				
31	Storage Shed		1990	(4,980)				
32	Audit Adj 7/1/03 (#6) - Pg 12 Line 30		1990	950				
33	Land Improvements		1990	11,382				
34	Building Improvements		1990	3,186				
35	Building (Bldg)		1990	(3,186)				
36	Audit Adj 7/1/03 (#9) - Pg 12, Line34							

*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 Macomb

0049585

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	Building Improvements	1991	\$ 5,547	\$		\$	\$	\$	37
38	Building Improvements	1992	10,800						38
39	Land Improvements	1993	23,517						39
40	Building Improvements	1993	13,585						40
41	Building Improvements	1994	51,433						41
42	Land Improvements	1995	4,302						42
43	Building Improvements	1995	121,882						43
44	SMOKE DAMPER	1996	853						44
45	WALLCOVERING	1996	358						45
46	TILE	1996	5,333						46
47	PLUMBING FOR BEAUTY SHOP	1996	3,735						47
48	CABINETS IN PERSONAL CARE	1996	2,450						48
49	ELECTRICAL WIRING FOR PERSONAL	1996	1,740						49
50	TILE FLOOR	1996	824						50
51	ADDITIONAL COST TILE FLOOR	1996	189						51
52	PAINT	1996	1,025						52
53	ADDITIONAL COST A/C (DUCTWORK)	1996	262						53
54	CARPET	1996	846						54
55	COUNTERTOP	1996	894						55
56	PAINTING	1996	1,172						56
57	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278						57
58	HVAC	1996	600						58
59	WALLCOVERING	1996	2,112						59
60	FLOORING	1996	514						60
61	ADDITIONAL WALLCOVERING	1996	6						61
62	WALLCOVERING	1996	382						62
63	CONCRETE	1996	8,812						63
64	PAVING	1996	7,710						64
65	PAVING	1996	13,835						65
66	RENOVATION CHARGES (DUMPSTER)	1996	210						66
67	PAVING-AUDIT ADJ 7/1/03 (#10) - CHG YR	1996	2,652						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,458,287	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	70

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

Facility Name & ID Number Heartland of Macomb

0049585

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		\$ 2,458,287	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	ANGLE BRACKETS FOR HANDRAIL	1997	700						2
3	WALLCOVERING	1997	599						3
4	HANDRAIL	1997	10,069						4
5	PAINTING & WALLCOVERING	1997	15,003						5
6	PAINTING	1997	2,500						6
7	ADDITIONAL COST FOR HANDRAIL	1997	1,480						7
8	COVE BASE	1997	671						8
9	WALL PROTECTION	1997	2,192						9
10	PAINTING & WALLCOVERING	1997	18,964						10
11	(2) NURSES STATION SYSTEMS	1997	11,176						11
12	WALLCOVERING	1997	24						12
13	ELECTRICAL WIRING, OUTLETS & T	1997	3,420						13
14	PAINTING, WALLCOVERING & COVE	1997	19,206						14
15	ADDLT COST FOR A/C	1997	105						15
16	NURSES STATION SYSTEM	1997	4,625						16
17	RENOVATE SHOWER ROOM	1997	939						17
18	A/C HEAT	1997	15,762						18
19	ROOF	1997	3,444						19
20	RENOVATE CENTRAL BATH	1997	2,475						20
21	PLUMBING IN KITCHEN	1997	1,102						21
22	ADDL'T COST FOR A/C	1997	105						22
23	VINLY WALL COVERING FROM INVENTORY	1997	2,425						23
24	HVAC	1997	682						24
25	ADDL'T COST FOR GENERATOR	1997	2,233						25
26	NURSES STATION SYSTEM	1997	1,600						26
27	CABINETS FOR BKKPG & MED RECOR	1997	5,432						27
28	HVAC (ADDL'T COST)	1997	880						28
29	ADDL'T RENOVATION COST	1997	28						29
30	REMODEL BOOKKEEPING OFFICE	1997	150						30
31	ADDL'T GENERATOR COST	1997	120						31
32	CARPET	1997	737						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,135	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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		\$ 2,587,135	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	DRYWALL	1997	2,750						2
3	PERIMETER ALARM SYSTEM	1997	5,972						3
4	WALLCOVERING	1997	651						4
5	SIDEWALKS	1997	5,875						5
6	Ceiling Tile For Nurses Station	1998	1,446						6
7	Additional Cost for Tile Floor	1998	291						7
8	Wallcovering	1998	414						8
9	Misc Labor & Materials for Gutters	1998	215						9
10	Excavation of Ditch & Storm Sewers	1998	975						10
11	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						11
12	ELECTRICAL WIRING	1998	665						12
13	ADDL'T COST ON FLOORING	1998	16						13
14	ADDL'T COST FOR COUNTERTOPS	1998	604						14
15	TILE FLOOR	1998	704						15
16	CUMMINS/ONAN GENERATOR	1998	24,882						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						17
18	FIRE ALARM CONTROL PANEL	1998	7,925						18
19	A/C HEAT ROOF	1998	672						19
20	GENERATOR	1998	303						20
21	FIRE ALARM SYSTEM	1998	17,066						21
22	GENERATOR	1998	25,364						22
23	HVAC RENOVATION	1998	646						23
24	Audit Adj 7/1/03 (#11) - Pg 12C, Line 23	1998	(646)						24
25	HVAC	1998	283,462						25
26	Audit Adj 7/1/03 (#12) - Pg 12C, Line 25	1998	(5,103)						26
27	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						27
28	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						28
29	PAINTING & WALLCOVERING	1999	3,457						29
30	DUCTWORK	1999	467						30
31	RE-KEY FACILITY	1999	779						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,993,418	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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		\$ 2,993,418	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	OVERHEAD FROM CONSTRUCTION	1999	4,880						2
3	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 2	1999	(4,880)						3
4	OVERHEAD FROM CONSTRUCTION	1999	27,042						4
5	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 4	1999	(27,042)						5
6	PAINTING	1999	1,245						6
7	EXIT FIXTURES	1999	2,074						7
8	ARMSTRONG FLOORING	1999	443						8
9	SPRINKLER UPGRADE	1999	14,500						9
10	LOCKING DOOR HARDWARE	1999	2,516						10
11	SPRINKLER UPGRADE	1999	14,500						11
12	DOOR LOCKS	1999	1,434						12
13	PLUMBING IN RESTROOMS	1999	1,330						13
14	SPRINKLER UPGRADE	1999	26,084						14
15	EXIT LIGHT	1999	2,074						15
16	FLOW SWITCH FOR SPRINKLER SYST	1999	342						16
17	QUARRY TILE	1999	9,916						17
18	SPRINKLER UPGRADE	1999	5,798						18
19	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 18	1999	(2,900)						19
20	SMOKE DOORS	1999	1,184						20
21	HVAC	1999	1,557						21
22	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						22
23	DOORS AND DOOR OPENERS	1999	3,500						23
24	DOORS AND FRAMES	1999	11,283						24
25	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						25
26	SECURE CARE SYSTEM	1999	15,373						26
27	DOORS	1999	2,750						27
28	DOOR	1999	200						28
29	EXTERIOR DOORS	1999	10,170						29
30	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						30
31	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 30	1999	(2,146)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,124,941	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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		\$ 3,124,941	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	DOOR ALARM	1999	1,475						2
3	SIDEWALKS	1999	9,020						3
4	SMOKING SHELTER	1999	4,950						4
5	PAVING	1999	4,950						5
6	WALLCOVERING	2000	61						6
7	UPGRADE FIRE ALARM SYST	2000	1,121						7
8	CABINETS FOR BUSINESS OFFICE	2000	2,821						8
9	ELECTRICAL FOR BUS OFFICE	2000	375						9
10	ALARM SYSTEM REPAIRS	2000	808						10
11	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						11
12	AUDIT ADJ 7/1/03 (#15) - PG12E, LINE 11	2000	(10,258)						12
13	HVAC	2000	18,151						13
14	HVAC CONSULTANT	2000	1,080						14
15	CARPET	2000	820						15
16	ADDL'T COST COUNTER TOPS	2000	313						16
17	CABINETS	2000	2,391						17
18	CARPET	2000	1,931						18
19	THERMO STAT	2000	1,594						19
20	FRT ON CARPET	2000	72						20
21	SOIL UTILITY RENOVATION	2000	3,240						21
22	SOIL UTILITY RENOVATION	2000	360						22
23	CABINETS/COUNTERTOPS	2000	266						23
24	KITCHEN HVAC	2000	2,017						24
25	SOIL UTILITY RENOVATION	2000	2,640						25
26	DUMPSTER ENCLOSURE	2001	2,457						26
27	WALLCOVERINGS	2001	121						27
28	ADDITONAL COST PAINTING & VWC	2001	1,238						28
29	PAINTING & VWC	2001	138						29
30	CUSTOM CABINETS	2001	5,289						30
31	INSTALL CARPET	2001	641						31
32	(42) WINDOWS & INSTALLATION	2001	22,328						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,217,609	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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		\$ 3,217,609	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						2
3	PAINTING	2001	2,880						3
4	PAINTING	2001	320						4
5	General Constr. - Plumbing	2002	1,236						5
6	Interior Renov. - Wallcoverings	2002	822						6
7	AUDIT ADJ 7/1/03 (#16) - PG12F, LINE 6	2002	(822)						7
8	Interior Renov. - Wallcoverings	2002	44,760						8
9	Interior Renov. - Plumbing	2002	1,394						9
10	Building Addition - Wallcovering	2002	4,077						10
11	Border	2002	154						11
12	Additional Cost - Wallcovering	2002	196						12
13	Additional Cost - Wallcovering	2002	481						13
14	HVAC Electrical & Plumbing	2002	33,930						14
15	HVAC Electrical & Plumbing	2002	3,770						15
16	VWC	2002	496						16
17	Building Addition - Landscaping	2002	1,190						17
18	Building Addition - Landscaping	2002	6,442						18
19	Flooring and VWC	2002	4,823						19
20	Carpeting, Painting and Wallcovering	2003	12,897						20
21	7/1/06 Capital Rate Adj #1	2003	(12,897)						21
22	Developers Costs - Overhead	2003	211,116						22
23	7/1/06 Capital Rate Adj #2	2003	(211,116)						23
24	Architect & Engineering Fees	2003	91,070						24
25	Reproduc, Permit & Plan Fees	2003	15,980						25
26	7/1/06 Capital Rate Adj #3	2003	(5,165)						26
27	7/1/06 Capital Rate Adj #4	2003	(10,815)						27
28	Developers Costs - Interest	2003	16,397						28
29	7/1/06 Capital Rate Adj #5	2003	(16,397)						29
30	Millwork & Electric Service	2003	17,781						30
31	7/1/06 Capital Rate Adj #6	2003	(4,641)						31
32	7/1/06 Capital Rate Adj #7	2003	(13,140)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,417,309	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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		\$ 3,417,309	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	Developers Costs - Overhead	2003	3,196						2
3	7/1/06 Capital Rate Adj #8	2003	(3,196)						3
4	Developers Costs - Interest	2003	276						4
5	7/1/06 Capital Rate Adj #9	2003	(276)						5
6	Carpeting, Painting and Wallcovering	2003	47,947						6
7	Soil & Concrete Testing	2003	3,480						7
8	Water & Sewer Fees	2003	120						8
9	7/1/06 Capital Rate Adj #10	2003	(120)						9
10	Site Work General Contractor	2003	32,561						10
11	7/1/06 Capital Rate Adj #11	2003	(32,561)						11
12	Retro Cost Adjustment	2003	45,504						12
13	7/1/06 Capital Rate Adj #12	2003	(45,504)						13
14	Window Treatments	2003	8,850						14
15	Soil and Concrete Testing (Addtl Costs)	2003	2,110						15
16	7/1/06 Capital Rate Adj #15	2003	(2,110)						16
17	Engineering Fees	2003	9,194						17
18	7/1/06 Capital Rate Adj #16	2003	(9,194)						18
19	Double Egress Door	2004	5,905						19
20	Construction Drawings & Specs	2004	5,998						20
21	Carpetry, Case Work, Painting	2004	37,880						21
22	Retainage for Addition	2005	1,533						22
23	Flooring, Corner Guards	2005	14,903						23
24	7/1/06 Capital Rate Adj #13	2005	(1,455)						24
25	7/1/06 Capital Rate Adj #14	2005	(55)						25
26	Materials to Complete Addition Project	2005	24,280						26
27	Physical Therapy Addn - LI - Soil Testing	2006	3,773						27
28	Physical Therapy Addn - LI - Landscaping	2006	24,893						28
29	Physical Therapy Addn - LI - Permit Fees	2006	5,423						29
30	Physical Therapy Addn - BI - Genl Contracting	2006	428,270						30
31	Physical Therapy Addn - BI - Carpeting	2006	6,948						31
32	Physical Therapy Addn - BI - Electrical	2006	288						32
33	Physical Therapy Addn - BI - Arch & Eng	2006	51,475						33
34	TOTAL (lines 1 thru 33)		\$ 4,087,645	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

Facility Name & ID Number Heartland of Maccomb

0049585

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 12G, Carried Forward		\$ 4,087,645	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	Physical Therapy Addn - BI - Genl A/H	2006	17,950						2
3	Corr & Main Dining Room - BI - Genl O/H	2006	7,409						3
4	Corr & Main Dining Room - BI - Carpentry	2006	26,688						4
5	Corr & Main Dining Room - BI - Wallcovering	2006	36,561						5
6	HR Office, BB Shop Renovation - BI - Carpet, Wallcovering	2007	6,145						6
7	Fire Safety Caulking	2007	24,060						7
8	Siding and Soffits on Gar	2007	5,100						8
9	Fire Walls and Caulking	2007	24,060						9
10	Cabinets in Beauty Shop	2007	2,982						10
11	FIRE WALLS AND CHALKING	2007	(24,060)						11
12	RENOVATE BREAKROOM - PLUMBING	2008	1,174						12
13	RENOVATE BREAKROOM - CABINETRY	2008	2,321						13
14	RENOVATE BREAKROOM - CEILING	2008	853						14
15	RENOVATE BREAKROOM - PAINTING	2008	704						15
16	RENOVATE BREAKROOM - VINYL TILE FLOORING (VCT)	2008	1,323						16
17	PAINTING CLOSETS	2008	9,850						17
18	ADJ PAINTING CLOSETS	2008	4,174						18
19	Water Heater	2009	16,031						19
20	Water Heater	2009	1,781						20
21	BI 010345 plumbing for asset 10342-dishwasher	2010	19,574						21
22									22
23	00000010354 WATER LINES	2010	8,600						23
24	00000010355 roof duct	2011	14,367						24
25	00000010356 Add'l cost roof duct	2011	8,499						25
26	00000010371 HEAT EXCHANGER	2011	3,835						26
27	00000010372 Add'l cost roof duct	2011	2,520						27
28	00000010374 VWC, BASE, & CHAIR RAILS	2011	5,550						28
29	00000010375 VWC & ORDER, PAINT	2011	5,277						29
30	00000010397 STORAGE SHED	2012	4,500						30
31									31
32	10403 ICE MACH IN MAIN DINING ROOM	2013	8,600						32
33	10404 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						33
34	TOTAL (lines 1 thru 33)		\$ 4,336,048	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,336,048	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	1
2	10405 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						2
3	10409 SEWER LINE REPLACEMENT	2013	123,120						3
4	10412 0513 Roof Replacement-Main Bldg	2013	195,307						4
5	10414 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						5
6	10415 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						6
7									7
8	00000010421 80 GAL HOT WATER HEATER replaced	2014	16,110						8
9	00000010429 PAVING-asphalt patching	2014	12,004						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)		\$ 4,695,064	\$ 135,219		\$ 135,219	\$	\$ 2,949,097	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	\$ 1,439,240	\$ 47,780	\$ 47,780	\$		\$ 1,295,067	71
72	Current Year Purchases	28,480						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			6,558	6,558			74
75	TOTALS	\$ 1,467,720	\$ 47,780	\$ 54,338	\$ 6,558		\$ 1,295,067	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	Transport Residents	1986 Chevy Van	1986	\$ 20,573	\$	\$	\$		\$ 20,573	76
77		Chair life for van	1990	1,260					1,260	77
78		Running board for van	1995	877					877	78
79										79
80	TOTALS			\$ 22,710	\$	\$	\$		\$ 22,710	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)	\$ 6,291,739	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 182,999	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,557	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,558	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,266,874	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: \$ 36,958 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>2008 Ford X E-350 Cutaw</u>	\$ _____	\$ <u>9,633</u>	17
18					18
19				<u>above figure includes</u>	19
20				<u>gas & maintenance</u>	20
21	TOTAL		\$ _____	\$ <u>9,633</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.

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		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	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	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	1657	hrs	\$ 72,153		\$	87	1,657	\$ 72,240	1
2	Licensed Speech and Language Development Therapist	10a	1821	hrs	79,319	42	2,983	12	1,863	82,314	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3720	hrs	161,992			4,645	3,720	166,637	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				127,218		127,218	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						25,644		25,644	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					68,249			68,249	13
14	TOTAL				\$ 313,464	42	\$ 71,232	\$ 157,606	7,240	\$ 542,302	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 Macomb

0049585

Report 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 62	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>122,429</u>)	722,716		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)	\$ 722,778	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	4,695,063		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,490,430		16
17	Accumulated Depreciation (book methods)	(4,266,873)		17
18	Deferred Charges	2,513,300		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)	\$ 4,538,165	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,260,943	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 57,443	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,654		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,159		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>	70,134		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 392,390	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	581,402		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)	\$ 581,402	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 973,792	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,287,151	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,260,943	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,330,504	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,330,504	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(52,823)	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)	\$ (52,823)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	9,470	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 9,470	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,287,151	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	\$ 5,670,894	1	
2	Discounts and Allowances for all Levels	(2,013,744)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,657,150	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,704,072	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,704,072	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	1,039	12	
13	Barber and Beauty Care	10,359	13	
14	Non-Patient Meals	21,826	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	259,628	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	66,744	19	
20	Radiology and X-Ray	28,831	20	
21	Other Medical Services	19,785	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 408,212	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)	\$ 5,769,434	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	821,857	31	
32	Health Care	2,359,077	32	
33	General Administration	1,360,144	33	
B. Capital Expense				
34	Ownership	842,194	34	
C. Ancillary Expense				
35	Special Cost Centers	275,315	35	
36	Provider Participation Fee	163,670	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,822,257	40	
41	Income before Income Taxes (line 30 minus line 40)**	(52,823)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (52,823)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,509,693	44
45	Private Pay - Net Inpatient Revenue	1,298,417	45
46	Medicare - Net Inpatient Revenue	627,210	46
47	Other-(specify) <u>Hospice</u>	71,331	47
48	Other-(specify) <u>Insurance</u>	150,499	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,657,150	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 Macomb

0049585

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	1,854	2,020	\$ 67,748	\$ 33.54	1
2	Assistant Director of Nursing	3,672	4,002	106,784	26.68	2
3	Registered Nurses	16,170	17,621	374,382	21.25	3
4	Licensed Practical Nurses	12,588	13,717	255,322	18.61	4
5	CNAs & Orderlies	53,514	58,511	608,221	10.39	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	9,491	10,344	450,456	43.55	7
8	Rehab/Therapy Aides	4,054	4,418	123,294	27.91	8
9	Activity Director	3,616	3,944	52,086	13.21	9
10	Activity Assistants					10
11	Social Service Workers	3,541	3,865	84,455	21.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,333	3,664	44,747	12.21	15
16	Dishwashers					16
17	Maintenance Workers	2,118	2,312	42,815	18.52	17
18	Housekeepers	8,483	9,260	98,317	10.62	18
19	Laundry	1,719	1,876	17,579	9.37	19
20	Administrator	2,080	2,080	80,133	38.53	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,424	9,268	179,132	19.33	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	1,989	2,169	34,932	16.11	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	3,933	4,293	45,071	10.50	33
34	TOTAL (lines 1 - 33)	140,579	153,364	\$ 2,665,474 *	\$ 17.38	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	3,090	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)		\$ 3,090		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Heartland of Macomb

0049585

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$1618 & AHCA \$1114
- (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. \$ 32,906 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. \$ 163,670
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. \$ 24,411
- (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.