

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 N/A

	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	<u>81</u>	Skilled (SNF)	<u>81</u>	<u>29,565</u>	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	<u>81</u>	TOTALS	<u>81</u>	<u>29,565</u>	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>7,928</u>	<u>10,394</u>	<u>2,819</u>	<u>21,141</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,928</u>	<u>10,394</u>	<u>2,819</u>	<u>21,141</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.51%

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

None (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)

Meals on Wheels

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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 12/16/64

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

YES Date N/A NO

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

YES NO If YES, enter number

of beds certified 35 and days of care provided 2,819

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/15 Fiscal Year: 06/30/15

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

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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	279,991	20,283	5,533	305,807		305,807		305,807		1
2	Food Purchase		152,357		152,357		152,357	(25,783)	126,574		2
3	Housekeeping	89,180	21,459	299	110,938		110,938		110,938		3
4	Laundry	68,622	14,599	339	83,560		83,560		83,560		4
5	Heat and Other Utilities			99,638	99,638		99,638		99,638		5
6	Maintenance	67,016	8,886	35,611	111,513		111,513		111,513		6
7	Other (specify):* Trash/Waste Disposal			4,422	4,422		4,422		4,422		7
8	TOTAL General Services	504,809	217,584	145,842	868,235		868,235	(25,783)	842,452		8
	B. Health Care and Programs										
9	Medical Director			9,450	9,450		9,450		9,450		9
10	Nursing and Medical Records	1,391,969	93,326	3,040	1,488,335		1,488,335		1,488,335		10
10a	Therapy										10a
11	Activities	57,531	3,939	1,898	63,368		63,368		63,368		11
12	Social Services	46,795		1,898	48,693		48,693		48,693		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,496,295	97,265	16,286	1,609,846		1,609,846		1,609,846		16
	C. General Administration										
17	Administrative	67,059			67,059		67,059		67,059		17
18	Directors Fees										18
19	Professional Services			81,733	81,733		81,733	(5,116)	76,617		19
20	Dues, Fees, Subscriptions & Promotions			22,232	22,232		22,232	(244)	21,988		20
21	Clerical & General Office Expenses	100,808	12,609	35,276	148,693		148,693	(1,147)	147,546		21
22	Employee Benefits & Payroll Taxes			253,292	253,292		253,292	6,951	260,243		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,563	5,563		5,563		5,563		24
25	Other Admin. Staff Transportation			3,072	3,072		3,072		3,072		25
26	Insurance-Prop.Liab.Malpractice			50,999	50,999		50,999		50,999		26
27	Other (specify):*										27
28	TOTAL General Administration	167,867	12,609	452,167	632,643		632,643	444	633,087		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,168,971	327,458	614,295	3,110,724		3,110,724	(25,339)	3,085,385		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.

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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			78,868	78,868		78,868	(1,871)	76,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,313	27,313		27,313	(4,041)	23,272			32
33	Real Estate Taxes			4,097	4,097		4,097	(4,097)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,029	32,029		32,029		32,029			35
36	Other (specify):*											36
37	TOTAL Ownership			142,307	142,307		142,307	(10,009)	132,298			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,235	415,312	523,547		523,547	(231)	523,316			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,206	156,206		156,206		156,206			42
43	Other (specify):* Non-Allowable Cos			84,106	84,106		84,106	(84,106)				43
44	TOTAL Special Cost Centers		108,235	655,624	763,859		763,859	(84,337)	679,522			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,168,971	435,693	1,412,226	4,016,890		4,016,890	(119,685)	3,897,205			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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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	\$ (15,911)	43	1
2	Non Care Real Estate Taxes	(4,097)	33	2
3	Revenue Offset to Food	(18,832)	2	3
4	Reclass software fees	1,650	19	4
5	Revenue Offset to Misc Exp	(1,147)	21	5
6	Chamber & Rotary Dues	(90)	19	6
7	Nonallowable PAC Dues	(1,804)	20	7
8	Offset Oxygen Revenue	(231)	39	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(40,462)		49

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
N/A	N/A	N/A		N/A		N/A

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		\$	N/A		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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		\$			\$	\$ * 0	14

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

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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	Bruce Brown	President	Administrative	0.00	N/A	N/A	N/A	N/A	\$ N/A	N/A	1
2	Marcia Vidoni	Vice-President	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	2
3	Erik Huddlestun	Secretary	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	3
4	Sarah Holsapple-Miller	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	4
5	Mike Kirk	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	5
6	Ginny Collins-Knierim	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	6
7	Bob Dougherty	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	NA	7
8											8
9	*None of the board members have conducted buiness with the facilty.										9
10	*None of the board members have business that have conducted business with the facility.										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

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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

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

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3	N/A								3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	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	Preferred Bank		X	Technology	\$1,266.93	12/19/14	\$ 66,200	\$ 60,372	12/19/19	0.0550	\$ 1,774	1						
2												2						
3												3						
4							Audit adjustment to adjust N/P to				1,974	4						
5												5						
Working Capital																		
6	Preferred Bank		X	Line of Credit	None	8/31/2013	600,000	480,000	8/30/2014	0.0600	21,421	6						
7												7						
8	Various		X	Finance Charges							2,144	8						
9	TOTAL Facility Related				\$1,266.93		\$ 666,200	\$ 540,372			\$ 27,313	9						
B. Non-Facility Related*																		
10												10						
11											(2,144)	11						
12											(1,897)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (4,041)	14						
15	TOTALS (line 9+line14)						\$ 666,200	\$ 540,372			\$ 23,272	15						

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

* 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 2014 report.		\$	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.)	2014	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.)	Allocated from Management Co.	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	8	
	2011	9	
	2012	N/A	10
	2013		11
	2014		12
Facility is a not for profit entity and is exempt from real estate taxes.			
Real estate taxes are paid on non care assets; however, the tax is adjusted out of the cost report per instructions.			
			FOR BHF USE ONLY
13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	1
2					2
3	TOTALS	152,472		\$ 24,000	3

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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	60		1964	1964	\$ 385,838	\$	25	\$	\$	\$ 385,838	4
5			1966	1966	8,491		25			8,491	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	11,798		25			11,798	7
8	21		1996	1996	828,949	20,724	40	20,724		393,757	8
	Improvement Type**										
9		Building improvements		1973	7,123		10			7,123	9
10		Building improvements (less disposition of \$1,076 in '07-'08)		1974	27,871		14-30			27,871	10
11		Building improvements (less disposition of \$1,773 in 2005-06)		1975	5,291		10-30			5,291	11
12		Building improvements		1976	1,607		10-30			1,607	12
13		Building improvements		1977	1,808		7			1,808	13
14		Building improvements (less disposition of \$4,880 in 2006-07)		1978	1,281		5-15			1,281	14
15		Building improvements		1979	949		10			949	15
16		Building improvements		1980	5,829		7			5,829	16
17		Building improvements		1981	1,376		7			1,376	17
18		Building improvements		1982	11,926		3-30			11,926	18
19		Building improvements		1983	6,263		5			6,263	19
20		Building improvements (less disposition of \$1,974 in 2004-05)		1984	16,740		5-15			16,740	20
21		Building improvements (less disposition of \$480 in 2005-06)		1985	5,320		5-15			5,320	21
22		Building improvements (less disposition of \$28,007 in 2005-06)		1986	17,785		10-20			17,785	22
23		Building improvements (less disposition of \$157 in 2006-07)		1987	27,530		5-15			27,530	23
24		Building improvements		1988	4,282		12-15			4,282	24
25		Building improvements (less disposition of \$610 in '07-'08)		1989	2,259		15			2,259	25
26											26
27		Building improvements (less disposition of \$2,795 in 2002-03)		1991	631		10			631	27
28		Heating/air system		1992	80,277		20			80,277	28
29		Building improvements		1992	3,084		10			3,084	29
30		Building improvements		1992	2,168		10			2,168	30
31											31
32		Building improvements		1992	647		10			647	32
33		Building improvements		1992	4,263		15			4,263	33
34		Ceiling/floor		1992	49,923		20			49,923	34
35		Sprinkler system		1992	60,121		20			60,121	35
36		Storage shelving		1993	4,090		10			4,090	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

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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	Storage shelving	1993	\$ 1,003	\$	10	\$	\$	\$ 1,003	37
38	Resident security system	1993	3,909		20			3,909	38
39	Cabinets	1993	42,611		15-20			42,611	39
40	Heating/air/tubs	1993	29,226		20			29,226	40
41	Fire alarm system	1993	12,350		20			12,350	41
42	Plumbing and water system	1993	8,684		20			8,684	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	295	20	295		10,493	44
45	Building improvements	1995	22,859		10-20			22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		34,148	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		13,895	48
49	Sprinklers	1996	9,774	244	40	244		4,392	49
50	Painting	1996	4,052	101	40	101		1,681	50
51	General contractor fees	1996	7,841	196	40	196		3,528	51
52	Electrical	1996	18,390	460	40	460		8,067	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		11,844	53
54	Cubicle curtain tracking	1996	742	37	20	37		710	54
55	Room signs	1996	3,331	167	20	167		3,170	55
56	Emergency lighting Jones wing	1996	142	7	20	7		137	56
57	Bath systems Jones wing	1996	8,610	431	20	431		8,186	57
58	Sprinklers Jones wing	1996	340		10			340	58
59	Security locks Jones wing	1996	1,049	52	20	52		991	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		1,786	61
62	Air filtration Jones wing	1996	2,081	104	20	104		1,976	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750		10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		2,121	65
66	Plumbing	1996	4,640	130	20	232	102	4,608	66
67	Electrical work (less disposition of \$1,500 in 2005-06)	1996	3,162		20			3,162	67
68	Flooring	1996	2,400	120	20	120		2,260	68
69	Courtyard	1996	2,766	138	20	138		2,614	69
70	TOTAL (lines 4 thru 69)		\$ 1,919,114	\$ 26,674		\$ 26,776	\$ 102	\$ 1,399,967	70

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

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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		\$ 1,919,114	\$ 26,674		\$ 26,776	\$ 102	\$ 1,399,967	1
2	Concrete work entrance	1996	1,470	74	20	74		1,388	2
3	Building appraisal	1997	2,578	64	40	64		448	3
4	Chapel HVAC	1997	2,324	116	20	116		2,151	4
5	Stained glass window	1997	2,052	103	20	103		1,875	5
6	Steel door	1997	422	21	20	21		383	6
7									7
8									8
9	Hand rails	1997	5,252	263	20	263		4,729	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		10,322	11
12	Fire system work	1997	513	26	20	26		460	12
13	Key pad - security system	1997	360	18	20	18		321	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		799	15
16									16
17	Bed light installation	1998	1,826	91	20	91		1,580	17
18	Hand rails	1998	1,413	71	20	71		1,221	18
19	Sprinklers	1998	708	35	20	35		608	19
20	Generator bypass switch	1998	1,567	78	20	78		1,343	20
21									21
22	Lighting - kitchen	1998	985		20			546	22
23	Paging system	1998	516	26	20	26		438	23
24	Room divider remodeling	1998	391	20	20	20		334	24
25	Bathroom lighting	1998	1,090	27	20	55	28	920	25
26	South wing remodeling	1998	165	8	20	8		64	26
27	Roof over generator room	1998	568	28	20	28		475	27
28	Bathrooms	1998	7,394	370	20	370		6,195	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		5,150	29
30	Fire Alarm System	1999	1,317	66	20	66		1,071	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		1,337	31
32		1999	1,760	44	20	88	44	1,423	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,974,070	\$ 29,237		\$ 29,411	\$ 174	\$ 1,445,548	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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		\$ 1,974,070	\$ 29,237		\$ 29,411	\$ 174	\$ 1,445,548	1
2	Generator panel	2000	2,023		10			2,023	2
3	Gazebo	2000	2,733		10			2,733	3
4	Anti-scald valves (2)	2001	655		10			655	4
5	Shower floor replacement	2001	500	25	20	25		363	5
6	Dining room lights	2001	6,013	150	20	301	151	4,362	6
7									7
8	Toilet stools & seats	2001	1,414		10			1,414	8
9	Parking lot asphalt reseal	2001	5,032	252	20	251	(1)	3,455	9
10	Ceramic wall tile	2001	365	18	20	18		249	10
11	Washer & nurse call	2001	485		10			485	11
12	Bath fans	2001	150		10			150	12
13	Extend legs on links	2001	607		10			607	13
14	Wallpaper front lobby	2001	150		10			150	14
15	Remodel North & South showers	2002	2,332	117	20	116	(1)	1,541	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912		10			912	16
17	Water heater	2002	4,165	104	20	208	104	2,723	17
18									18
19	Compressor - freezer	2002	810		10			810	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		417	20
21	Carpet	2003	2,887	144	20	144		1,838	21
22	Bypass switch for generator	2003	2,166	108	20	108		1,315	22
23	Sign	2003	850		10			850	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		2,196	25
26	Water Heater	2004	6,548	327	20	327		3,790	26
27	Wireless Monitoring System	2004	4,263		10			4,263	27
28	Water heater	2004	3,475	174	20	174		1,985	28
29	Lights, smoke detectors, other	2004	2,562		10			2,562	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		\$ 2,033,608	\$ 30,897		\$ 31,324	\$ 427	\$ 1,487,396	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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		\$ 2,033,608	\$ 30,897		\$ 31,324	\$ 427	\$ 1,487,396	1
2	Security fence (less disposition of \$2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		2,904	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		2,906	4
5	Windows - South Wing	2005	5,499	275	15	275		2,956	5
6	Windows - H Wing	2005	4,132	207	20	207		2,207	6
7	Handrails	2005	1,375	92	20	92		972	7
8	2 ton compressor	2005	558	37	15	37		446	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		6,386	10
11	Generator	2005	20,000	2,000	10	2,000		19,000	11
12									12
13	Roof	2006	10,657	273	39	273		2,457	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		1,301	14
15									15
16	Roof Repair	2008	4,587	167	27.5	167		1,169	16
17									17
18	Canopy Sprinkler System	2008	9,685	646	15	646		4,414	18
19	Jones Wing Door Alarms	2008	3,706	124	15	247	123	1,626	19
20	Hutton Wing New Doors	2009	5,100	340	15	340		2,210	20
21									21
22	Light Fixtures-All Areas	2010	19,737	1,038	20	987	(51)	5,017	22
23									23
24	Water Heater	2011	4,153	208	20	208		936	24
25	Door	2011	2,955	148	15	197	49	887	25
26									26
27	Backup Generator Meter	2011	3,467	173	20	173		606	27
28									28
29	Kitchen A/C Unit	2012	7,084	472	15	472		1,652	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,161,456	\$ 38,466		\$ 39,014	\$ 548	\$ 1,547,448	34

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

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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		\$ 2,161,456	\$ 38,466		\$ 39,014	\$ 548	\$ 1,547,448	1
2									2
3	Water Heater	2013	4,385	219	20	219		548	3
4	Generator Transfer Switch	2013	2,965	148	20	148		370	4
5	Condensing Unit for Walkway	2013	4,768	318	15	318		795	5
6									6
7	Landscaping & fountain in front of facility	2014	7,280	182	20	364	182	546	7
8	Installation of digital phone system	2014	6,262		5	1,252	1,252	1,879	8
9	Wiring and labor for installation of EHR capability	2014	7,241	30	20	362	332	543	9
10	Replace condenser on A/C - Dining Room Area	2014	3,323	12	20	166	154	249	10
11	Front office remodel: carpet, paint & tiling	2014	3,157	23	20	158	135	237	11
12									12
13	Water Softener - Mechanical Room	2014	2,642	99	10	132	33	132	13
14	Water Heater Southwest Shower	2014	4,385	146	10	219	73	219	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	To reconcile to financial statements			5,445			(5,445)		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)		\$ 2,207,864	\$ 45,088		\$ 42,353	\$ (2,735)	\$ 1,552,966	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	\$ 169,554	\$ 18,685	\$ 21,822	\$ 3,137	3-20 years	\$ 132,952	71
72	Current Year Purchases	73,030	13,695	11,422	(2,273)	3-15 years	11,422	72
73	Fully Depreciated Assets	427,551					427,551	73
74								74
75	TOTALS	\$ 670,135	\$ 32,380	\$ 33,244	\$ 864		\$ 571,925	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	Resident Care	1994 Ford Van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77	Resident Care	2005 Chevy Venture Van	2014	7,000	1,400	1,400		5	2,100	77
78										78
79										79
80	TOTALS			\$ 48,610	\$ 1,400	\$ 1,400	\$		\$ 43,710	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)	\$ 2,950,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,997	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,871)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,168,601	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	See Schedule 13A Attached	\$ 161,400	\$ 2,185	\$ 117,979	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 161,400	\$ 2,185	\$ 117,979	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name: Heartland Manor Nursing Ctr
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2015

Schedule 13A

XI. Ownership Costs

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

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Aklinski Building	1994	40,045	1,027		(1,027)		21,306
	Aklinski concrete work	1994	3,900	195		(195)		3,640
	Land		30,000			-		30,000
	Repp House	1998	38,500	963		(963)		14,078
	Architect fees for Assisted Living	2005	2,915			-		2,915
	410 NW 3rd Street - Land		46,040			-		46,040
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			161,400	2,185	-	(2,185)		117,979

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 32029

Description: Please see SCH 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			<u>N/A</u>		19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name: Heartland Manor Nursing Ctr
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2015

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
CPM Units	2,250
Dishwasher	1,029
Mattresses	5,770
Oximeter	400
Oxygen Equipment	17,188
Washer/Dryer	4,342
Wheelchair	1,050
Total - Line 16	<u>32,029</u>

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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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			
		1	2	3	4
		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	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	Ln 39, C3	hrs	\$	2,041	\$ 114,906	\$	2,041	\$ 114,906	1
2	Licensed Speech and Language Development Therapist	Ln 39, C3	hrs		611	29,149		611	29,149	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 39, C3	hrs		4,250	271,257		4,250	271,257	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				98,407		98,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Ther Supplies</u>	L39, C2					9,597		9,597	12
13	Other (specify): <u>Oxygen</u>	L39, C2					231		231	13
14	TOTAL			\$	6,902	\$ 415,312	\$ 108,235	6,902	\$ 523,547	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2015**

(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	\$ 94,569	\$ 94,569	1
2	Cash-Patient Deposits	8,493	8,493	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>38,080</u>)	1,341,684	1,341,684	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,640	23,640	6
7	Other Prepaid Expenses	37,654	37,654	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Valuation Allowance</u>	19,800	19,800	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,525,840	\$ 1,525,840	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	351	351	12
13	Land	120,585	24,000	13
14	Buildings, at Historical Cost	2,251,527	2,207,864	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	623,236	718,745	16
17	Accumulated Depreciation (book methods)	(2,065,427)	(2,168,601)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Security Deposits</u>)	334	334	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 930,606	\$ 782,693	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,456,446	\$ 2,308,533	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 380,809	\$ 380,809	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,593	8,593	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,449	146,449	30
31	Accrued Taxes Payable (excluding real estate taxes)	80,616	80,616	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	22,227	22,227	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 638,694	\$ 638,694	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	540,372	540,372	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)	\$ 540,372	\$ 540,372	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,179,066	\$ 1,179,066	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,277,380	\$ 1,129,467	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,456,446	\$ 2,308,533	48

*(See instructions.)

Facility Name: Heartland Manor Nursing Ctr
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2015

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Balance Transfer Clearing Account	76	76
401k Payables	390	390
Insurance Payables	(550)	(550)
Employee Deductions - Credit Union	15	15
Unearned Room Revenue	22,296	22,296
Total - Line 36	22,227	22,227

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,187,834	1
2	Restatements (describe):		2
3	Prior Period Adjustment	16,395	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,204,229	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,151	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)	\$ 73,151	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,277,380	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

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	\$ 2,910,728	1
2	Discounts and Allowances for all Levels	14,103	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,924,831	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	992,721	6
7	Oxygen	3,360	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 996,081	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	18,832	14
15	Telephone, Television and Radio	1,746	15
16	Rental of Facility Space	9,625	16
17	Sale of Drugs	83,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,768	19
20	Radiology and X-Ray		20
21	Other Medical Services	36,740	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,444	23
D. Non-Operating Revenue			
24	Contributions	6,034	24
25	Interest and Other Investment Income***	1,897	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,931	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	2,754	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,754	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,090,041	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	868,235	31
32	Health Care	1,609,846	32
33	General Administration	632,643	33
B. Capital Expense			
34	Ownership	142,307	34
C. Ancillary Expense			
35	Special Cost Centers	607,653	35
36	Provider Participation Fee	156,206	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,016,890	40
41	Income before Income Taxes (line 30 minus line 40)**	73,151	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,151	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,359,874	44
45	Private Pay - Net Inpatient Revenue	1,109,818	45
46	Medicare - Net Inpatient Revenue	455,139	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,924,831	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No ^ 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.
 "^-This entity is a cash basis taxpayer"

Facility Name: Heartland Manor Nursing Ctr
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2015

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Adult Day Care	535
Oil Income	1,072
Miscellaneous Income	1,147
Total - Line 28	<u>2,754</u>

Facility Name & ID Number Heartland Manor Nursing Ctr

0002923

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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	2,093	2,683	\$ 67,443	\$ 25.14	1
2	Assistant Director of Nursing	601	601	12,922	21.50	2
3	Registered Nurses	9,349	9,886	221,439	22.40	3
4	Licensed Practical Nurses	21,745	23,069	432,429	18.75	4
5	CNAs & Orderlies	50,032	52,993	587,549	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,954	2,080	27,822	13.38	9
10	Activity Assistants	2,932	3,087	29,709	9.62	10
11	Social Service Workers	3,420	3,675	46,795	12.73	11
12	Dietician					12
13	Food Service Supervisor	1,836	2,080	34,094	16.39	13
14	Head Cook	6,358	6,931	64,394	9.29	14
15	Cook Helpers/Assistants	22,004	22,004	181,503	8.25	15
16	Dishwashers					16
17	Maintenance Workers	3,827	4,191	67,016	15.99	17
18	Housekeepers	8,969	9,596	89,180	9.29	18
19	Laundry	5,540	5,946	68,622	11.54	19
20	Administrator	1,926	2,080	67,059	32.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,735	6,268	100,808	16.08	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	2,024	2,154	24,817	11.52	31
32	Other Health C: <u>MDS Coordinator</u>	2,030	2,271	45,370	19.98	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,375	161,595	\$ 2,168,971 *	\$ 13.42	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	96	\$ 5,533	L1, C3	35
36	Medical Director	12	9,450	L9, C3	36
37	Medical Records Consultant	16	2,020	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,020	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,898	L11, C3	44
45	Social Service Consultant	24	1,898	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	208	\$ 21,819		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Penny Chrysler	Administrator	0	\$ 67,059	Workers' Compensation Insurance	\$ 45,068	IDPH License Fee	\$ 1,990				
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	52				
				FICA Taxes	199,565	Health Care Worker Background Check (Indicate # of checks performed <u>5</u>)	150				
				Employee Health Insurance		Patient Background Checks	1,376				
				Employee Meals	6,951	Miscellaneous Licenses & Fees	1,045				
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	12,921				
				Miscellaneous Employee Benefits	3,974	IL Healthcare Assoc. Dues	4,698				
				Labs & Physicals	4,685	Electronic Medical Records	1,650				
				Employee Life Insurance		Less: Rotary Dues	(90)				
						Less: Public Relations Expense	()				
						Non-allowable advertising	(1,804)				
						Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,059	TOTAL (agree to Schedule V, line 22, col.8)		\$ 260,243	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,988		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount			
N/A			\$	N/A		\$	Out-of-State Travel	\$			
							In-State Travel	2,208			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	3,355			
C. Professional Services				TOTAL				Entertainment Expense			
Vendor/Payee	Type	Amount						()			
Quorum Consulting Group	401(k) Administrator	\$ 2,750									
McGladrey LLP	Accounting	19,613									
Larson, Woodyard & Henson LLP	Accounting	32,605									
Duane Morris	Legal	26,067									
Personal Planners	Consulting	698									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 81,733	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,563		

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Heartland Manor Nursing Ctr
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 81,733

Less: Non-Allowable Collection Fees (5,116)

Total (agree to Schedule V, line 19, column 8) 76,617

Facility Name & ID Number Heartland Manor Nursing Ctr# 0002923Report Period Beginning: 7/1/2014Ending: 6/30/2015**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. Illinois Health Care Assoc. \$4,698
- (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? N/A
- (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? 3-15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,375 Line L10, C2
- (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? No
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 156,206
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. \$ 6,951 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,832
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees