

		FOR BHF USE					

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0049536</u></p> <p>Facility Name: <u>Heartland of Normal</u></p> <p>Address: <u>510 Broadway</u> <u>Normal</u> <u>61761</u> Number City Zip Code</p> <p>County: <u>McLean</u></p> <p>Telephone Number: <u>(309) 452-4406</u> Fax # <u>(309) 454-7908</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/01/81</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jeff Lewandowski</u> Telephone Number: <u>(419) 252-5736</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/2014</u> to <u>05/31/2015</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;"> (Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # () </td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Heartland of Normal

0049536 Report Period Beginning: 06/01/2014 Ending: 05/31/2015

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 _____

	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	116	Skilled (SNF)	116	42,340	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	116	TOTALS	116	42,340	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	12,593	7,964	11,988	32,545	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,593	7,964	11,988	32,545	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.87%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 11/01/81

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

YES Date 04/07/11 NO

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

YES NO If YES, enter number of beds certified 116 and days of care provided 6,665

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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	133,885	32,231	173,376	339,492		339,492	339,492		1	
2	Food Purchase		261,320		261,320		261,320	(1,233)	260,087	2	
3	Housekeeping	159,058	23,855	7,435	190,348		190,348		190,348	3	
4	Laundry	40,994	24,265	58	65,317		65,317		65,317	4	
5	Heat and Other Utilities			167,891	167,891	1,824	169,715		169,715	5	
6	Maintenance	45,562	33,918	147,977	227,457		227,457		227,457	6	
7	Other (specify):* Med Waste			10,881	10,881		10,881		10,881	7	
8	TOTAL General Services	379,499	375,589	507,618	1,262,706	1,824	1,264,530	(1,233)	1,263,297	8	
	B. Health Care and Programs										
9	Medical Director			25,040	25,040		25,040		25,040	9	
10	Nursing and Medical Records	2,475,394	287,536	144,211	2,907,141	6,213	2,913,354		2,913,354	10	
10a	Therapy	1,060,167	13,499	41,247	1,114,913		1,114,913		1,114,913	10a	
11	Activities	67,505	13,611	194	81,310		81,310		81,310	11	
12	Social Services	179,720	10	3,851	183,581		183,581		183,581	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	3,782,786	314,656	214,543	4,311,985	6,213	4,318,198		4,318,198	16	
	C. General Administration										
17	Administrative	100,555		485,372	585,927	(231,136)	354,791		354,791	17	
18	Directors Fees									18	
19	Professional Services			19,880	19,880		19,880	(19,880)		19	
20	Dues, Fees, Subscriptions & Promotions			120,268	120,268		120,268	(83,861)	36,407	20	
21	Clerical & General Office Expenses	257,972	53,107	544,767	855,846		855,846	(455,618)	400,228	21	
22	Employee Benefits & Payroll Taxes			789,142	789,142	33,766	822,908		822,908	22	
23	Inservice Training & Education			4,743	4,743		4,743		4,743	23	
24	Travel and Seminar			23,872	23,872		23,872		23,872	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			284,258	284,258		284,258		284,258	26	
27	Other (specify):*									27	
28	TOTAL General Administration	358,527	53,107	2,272,302	2,683,936	(197,370)	2,486,566	(559,359)	1,927,207	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,520,812	743,352	2,994,463	8,258,627	(189,333)	8,069,294	(560,592)	7,508,702	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 Normal

#0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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			211,268	211,268	12,057	223,325		223,325			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,285,097	1,285,097	177,276	1,462,373	(1,308,215)	154,158			32
33	Real Estate Taxes			74,721	74,721		74,721		74,721			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			71,058	71,058		71,058		71,058			35
36	Other (specify):*											36
37	TOTAL Ownership			1,642,144	1,642,144	189,333	1,831,477	(1,308,215)	523,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		360,838	497	361,335		361,335		361,335			39
40	Barber and Beauty Shops			9,221	9,221		9,221		9,221			40
41	Coffee and Gift Shops	12,661			12,661		12,661		12,661			41
42	Provider Participation Fee			210,191	210,191		210,191		210,191			42
43	Other (specify):* IV X-Ray & Lab		121,230	104,203	225,433		225,433		225,433			43
44	TOTAL Special Cost Centers	12,661	482,068	324,112	818,841		818,841		818,841			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,533,473	1,225,420	4,960,719	10,719,612		10,719,612	(1,868,807)	8,850,805			45

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning: 06/01/2014

Ending: 05/31/2015

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	(1,233)	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	(100)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(317)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,912)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,755)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(452,469)	21		24
25	Fund Raising, Advertising and Promotional	(83,861)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,323,160)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,868,807)		\$	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)	\$ (1,868,807)		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	Exceptional Care Program					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 Normal

Report Period Beginning: 06/01/2014
 Ending: 05/31/2015

ID# 0049536

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. Income	\$ (131)	21	1
2	Vending Income	(689)	21	2
3	Accounting/Collection Fees	(13,725)	19	3
4	HCP Lease Interest	(1,308,215)	32	4
5	Cons Fees	(400)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,323,160)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,233)	0	0	0	0	0	0	0	0	0	0	(1,233)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,233)	0	(1,233)	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	(19,880)	0	0	0	0	0	0	0	0	0	0	(19,880)	19
20	Fees, Subscriptions & Promotions	(83,861)	0	0	0	0	0	0	0	0	0	0	(83,861)	20
21	Clerical & General Office Expenses	(455,618)	0	0	0	0	0	0	0	0	0	0	(455,618)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(559,359)	0	(559,359)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(560,592)	0	(560,592)	29									

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Normal# 0049536

Report Period Beginning:

06/01/2014 Ending:

Summary B

05/31/2015

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	(1,308,215)	0	0	0	0	0	0	0	0	0	0	(1,308,215)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,308,215)	0	0	0	0	0	0	0	0	0	0	(1,308,215)	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)	(1,868,807)	0	0	0	0	0	0	0	0	0	0	(1,868,807)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 485,372	HCR Manor Care Services, LLC	100.00%	\$ 485,372	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	4,533,473	Heartland Employment Services, LLC	100.00%	4,533,473		4
5	V	10a Therapy Management	12,112	Heartland Rehabilitation Services, LLC	100.00%	12,112		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		\$ 5,030,957			\$ 5,030,957	\$ *	14

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

Facility Name & ID Number

Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

VII. RELATED PARTIES

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

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

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 Normal

0049536

Report Period Beginning:

06/01/2014

Ending: 5/31/2015

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	564 NFs, HHs, & R	\$ 700,139		10,339,129	\$ 1,824	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	356 NFs			10,339,129	0	2
3	5	Utilities - Direct to Western Divisi	Accumulated Cost	45 NFs			10,339,129	0	3
4	10	Nursing - Pooled	Accumulated Cost	564 NFs, HHs, & R	365,628	262,581	10,339,129	952	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	356 NFs	1,781,417	1,228,977	10,339,129	5,260	5
6	10	Nursing - Direct to Western Divisi	Accumulated Cost	45 NFs				0	6
7	17	General & Administrative - Poole	Accumulated Cost	564 NFs, HHS & Re	68,653,771	35,393,585	10,339,129	178,825	7
8	17	General & Administrative - Direc	Accumulated Cost	356 NFs	12,665,127	2,400,695	10,339,129	37,399	8
9	17	General & Administrative - Direc	Accumulated Cost	40 NFs Jan-Sept	1,411,275		7,754,347	31,551	9
10	17	General & Administrative - Direc	Accumulated Cost	45NFs Oct-Dec	536,860		2,584,782	6,461	10
11	22	Employee Benefits - Pooled	Accumulated Cost	564NFs, HHs, & Re	5,418,631		10,339,129	14,114	11
12	22	Employee Benefits - Direct to All	Accumulated Cost	356 NFs	6,655,045		10,339,129	19,652	12
13	22	Employee Benefits - Direct to Wes	Accumulated Cost	45 NFs Oct-Dec			10,339,129	0	13
14	30	Depreciation - Pooled	Accumulated Cost	564 NFs, HHs, & R	3,871,414		10,339,129	10,084	14
15	30	Depreciation -Direct to All SNFs	Accumulated Cost	356 NFs	668,272		10,339,129	1,973	15
16	30	Depreciation - Direct to Western	Accumulated Cost	45 NFs Oct-Dec			10,339,129	0	16
17	32	Pooled Interest	Accumulated Cost		25,971,677		10,339,129	67,649	17
18	32	Directly Assigned Interest	Not Allocated		17,184,434			109,626	18
19		H/O Costs Allocated to Non-SNFs and Other Divisions			33,870,689				19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 179,754,379	\$ 39,285,838		\$ 485,370	25

Facility Name & ID Number

Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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**					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			\$ 1,668,364	\$ 1,668,364		6.5709	\$ 109,626					
2																
3																
4																
5																
	Working Capital															
6	Home Office Pooled Interest Expense										67,649					
7	Interest Income/Interest Expense										(23,118)					
8																
9	TOTAL Facility Related						\$ 1,668,364	\$ 1,668,364			\$ 154,157					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 1,668,364	\$ 1,668,364			\$ 154,157					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2014 report.		\$ 67,905	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.)		\$ 74,305	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 6,400	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 68,321	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.		\$ 74,721	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	<u>69,761</u>	8
	2011	<u>70,372</u>	9
	2012	<u>71,622</u>	10
	2013	<u>74,078</u>	11
	2014	<u>74,532</u>	12
Line 2: \$74,305 = \$37,039 for the 2nd half of 2013 + \$37,266 for the 1st half of 2014			
Line 4: \$68,321 = \$37,266 for the 2nd half 2014 + 31,055 estimate for Jan-May 2015			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Heartland of Normal

0049536 Report Period Beginning:

06/01/2014 Ending:

05/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,829 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	<u>Facility</u>		<u>1971</u>	<u>\$ 58,339</u>	<u>1</u>
2			<u>1993 & 2001</u>	<u>130,541</u>	<u>2</u>
3	TOTALS			\$ 188,880	3

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90		1971	1962	\$ 506,817	\$ 16,028		\$ 16,028		\$ 1,274,488	4
5	9			1994	497,564						5
6	10			2001	533,510						6
7	7			2006	480,167						7
8				2010	233,277						8
	Improvement Type**										
9	Current Year Depreciation					102,487		102,487		3,064,061	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18		RETIREMENTS		1987	(29,830)						18
19				1988	207,264						19
20				1989	134,621						20
21				1990	46,332						21
22				1991	15,386						22
23				1992	57,357						23
24		RETIREMENTS		1992	(3,110)						24
25				1993	44,829						25
26				1994	137,130						26
27				1995	72,481						27
28		RENOVATIONS-PATIENT ROOMS		1996	22,684						28
29		CARPET/TILE & INSTALLATION		1996	4,392						29
30		CAPITALIZED LABOR		1996	7,272						30
31		CR5/31/99 AUDIT ADJ - CAPITAL		1996	(7,272)						31
32		WALL VINYL/DRYWALL		1996	5,194						32
33		SIGNS/BOARDS		1996	1,730						33
34		INSTALL GRID/PANELS		1996	4,402						34
35		CONCRETE WALK/RAMP		1996	2,850						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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	
37	CABINETS	1996	\$ 1,087	\$		\$	\$	\$	37
38	CARPETING	1996	9,845						38
39	ROOFING	1996	24,474						39
40	ELECTRICAL/LIGHTING	1996	2,159						40
41	WALL COVERINGS	1996	5,910						41
42	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						42
43	INSTALL SHOWER TILE	1996	2,656						43
44	REPAIR COMPRESSOR	1996	900						44
45	CONCRETE WALK	1996	1,053						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALL COVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						55
56	PLUMBING/BATHROOM WORK	1997	1,226						56
57	ELECTRICAL	1997	2,416						57
58	FINISH/STUD	1998	4,865						58
59	PAINTING/WALL COVERINGS	1998	8,175						59
60	CARPETING	1998	6,460						60
61	PLUMBING	1998	1,456						61
62	ROOFING	1998	2,170						62
63	DOORS/WINDOWS/CASEWORK	1998	9,884						63
64	ELECTRICAL	1998	5,360						64
65	FLOORING/CEILING/COVE BASE	1998	13,283						65
66	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						66
67	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						67
68	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,724,503	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	70

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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		\$ 3,724,503	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	7/1/06 Capital Rate Adj	1998	2,520						17
18	GAZEBO	1998	2,495						18
19	7/1/06 Capital Rate Adj #2	1998	(2,495)						19
20	FLOORS	1999	2,990						20
21	DOORS	1999	18,097						21
22	FENCING	1999	4,343						22
23	SIDEWALK	1999	3,719						23
24	FIRE SPRINKLER	1999	6,270						24
25	WATER HEATER	1999	7,717						25
26	DOORS (adj vr per Capital Rate Adj #3)	1999	11,081						26
27	PAINTING (adj vr per Capital Rate Adj #4)	1999	28,868						27
28	FLOORS	2000	830						28
29	RENOVATION-ARCADIA ADDTN	2000	5,000						29
30	CONCRETE	2000	1,685						30
31	CARPENTRY	2000	3,179						31
32	DRYWALL/FINISHES	2000	15,397						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,889,557	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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		\$ 3,889,557	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	CEILING / FLOORING	2000	5,680						2
3	CAREPTING & PADS	2000	7,167						3
4	WALLCOVERING	2000	7,060						4
5	ELECTRICAL	2000	12,505						5
6	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						6
7	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(25,528)						7
8	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						8
9	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(5,447)						9
10	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						10
11	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(43,193)						11
12	WATER HEATER	2001	9,350						12
13	8 REPLACEMENT WINDOWS	2001	5,812						13
14	MIXING VALVE	2001	3,397						14
15	CARPET & VWC	2001	24,531						15
16	7/1/06 Capital Rate Adj #5	2001	(21,937)						16
17	SOIL & CONCRETE TESTING	2001	2,905						17
18	WATER & SEWER, PERMIT FEES	2001	14,582						18
19	7/1/06 Capital Rate Adj #6	2001	(13,611)						19
20	SITWORK	2001	74,254						20
21	7/1/06 Capital Rate Adj #7	2001	(74,254)						21
22	LANDSCAPING	2001	2,270						22
23	ADDITIONAL COST SITWORK	2001	371						23
24	7/1/06 Capital Rate Adj #8	2001	(371)						24
25	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #9)	2001	10,290						25
26	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #10)	2001	8,731						26
27	FRONT HALL & OFFICE WALLS / FLOORS	2002	29,012						27
28	FRONT HALL & OFFICE WALLS / FLOORS	2002	4,580						28
29	FLOORING BY GREASE TRAP	2002	753						29
30	FLOORING	2002	5,415						30
31	ADDITIONAL ARCHITECTURE ENG.	2002	65						31
32	ARCHITECTURE ENGINEERING	2002	350						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,008,464	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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		\$ 4,008,464	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	ARCHITECTURE ENGINEERING	2002	2,993						2
3	DIETARY HVAC	2002	82,214						3
4	7/1/06 Capital Rate Adj #11	2002	(21,512)						4
5	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						5
6	7/1/06 Capital Rate Adj #12	2002	(7,395)						6
7	SMOKE SHELTER	2002	3,540						7
8	ALUMINUM SHELTER	2002	5,225						8
9	SIDEWALK	2002	2,375						9
10	FENCE	2002	975						10
11	RETROACTIVE ADDITION	2002	(10)						11
12	7/1/06 Capital Rate Adj	2002	10						12
13	LANDSCAPING	2003	7,887						13
14	DEVELOPERS COST - OVERHEAD	2003	10,184						14
15	7/1/06 Capital Rate Adj #13	2003	(10,184)						15
16	INTEREST ON CONSTRUCTION	2003	722						16
17	7/1/06 Capital Rate Adj #14	2003	(722)						17
18	CARPENTRY	2003	3,460						18
19	FLOORING	2003	7,040						19
20	PAINTING	2003	33,211						20
21	WALLCOVERING	2003	6,434						21
22	HVAC	2003	3,587						22
23	VWC	2003	754						23
24	HANDRAILS & INSTALLATION	2003	2,300						24
25	VWC	2004	922						25
26	BORDER	2004	56						26
27	PAINT, VWC & BORDER	2004	1,300						27
28	CABINETS AND COUNTERTOPS	2004	5,671						28
29	FLOORING	2004	2,288						29
30	FLOORING	2004	7,170						30
31	PAINT & VWC	2004	7,200						31
32	CARPET	2004	868						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,174,422	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014

Ending:

05/31/2015

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		\$ 4,174,422	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	OVERLAY ASPHALT PARKING LOT	2004	9,662						2
3	PARKING LOT CONSTRUCTION AND PAVING (Cap Adj #15)	2004	55,622						3
4	PAINT & VINYL WALL COVERING	2004	1,189						4
5	PAINT & VINYL WALL COVERING	2004	3,497						5
6	VINYL WALL COVERING	2004	219						6
7	DOOR WITH LOCK	2004	3,461						7
8	EXIT PANEL	2004	1,995						8
9	VINYL COVERED TILE	2004	640						9
10	PAINTING	2004	1,450						10
11	VINYL WALL COVERING	2004	432						11
12	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						12
13	7/1/06 Capital Rate Adj #16	2004	(34,924)						13
14	ELECTRICAL WORK	2004	30,627						14
15	VINYL WALL COVERING	2004	56						15
16	VINYL COVERED TILE AND COVE BASE	2004	2,175						16
17	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						17
18	ELECTRICAL WORK	2004	4,342						18
19	ELECTRICAL WORK	2004	8,455						19
20	VINYL WALL COVERING	2004	1,279						20
21	13 PHONE LINES & JACKS	2004	3,520						21
22	ENGINEERING, OVERHEAD & INTEREST	2005	9,557						22
23	7/1/06 Capital Rate Adj #17	2005	(9,557)						23
24	VINYL WALL COVERING	2005	1,279						24
25	7/1/06 Capital Rate Adj #18	2005	(1,279)						25
26	VINYL WALL COVERING	2005	506						26
27	VINYL WALL COVERING	2005	526						27
28	VINYL WALL COVERING	2005	159						28
29	VINYL WALL COVERING	2005	257						29
30	VINYL WALL COVERING	2005	7,268						30
31	VINYL WALL COVERING	2005	2,749						31
32	VINYL WALL COVERING	2005	2,670						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,325,865	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014 Ending:

05/31/2015

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 12E, Carried Forward		\$ 4,325,865	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	VINYL WALL COVERING	2005	2,510						2
3	FLOORING VINYL	2005	1,980						3
4	KICK RAIL	2005	2,354						4
5	WINDOW TREATMENTS	2005	5,098						5
6	VINYL COVERED TILE & CARPET	2005	9,340						6
7	DOOR	2005	1,580						7
8	CEILING TILE	2005	29,500						8
9	OVERHEAD & INTEREST	2005	18,308						9
10	7/1/06 Capital Rate Adj #19	2005	(18,308)						10
11	ROOFING & SHEET METAL	2005	237,310						11
12	DUCT WORK	2005	6,802						12
13	SITE PREP, LANDSCAPING, UTILITIES	2006	52,007						13
14	SOIL & CONCRETE TESTING	2006	2,435						14
15	ELECTRICAL POWER SUPPLY	2006	2,295						15
16	ARCHITECT & ENGINEERING COSTS	2006	85,271						16
17	GENERAL OVERHEAD & INTEREST	2006	46,990						17
18	PLAN REVIEWS	2006	8,192						18
19	WALLCOVERINGS	2006	9,806						19
20	MILLWORK	2006	1,766						20
21	DINING ROOM RAILS	2007	2,950						21
22	DINING ROOM PAINTING	2007	3,950						22
23	ARCHITECT & ENGINEERING COSTS	2007	3,662						23
24	GENERAL OVERHEAD & INTEREST	2007	11,136						24
25	RESILIENT FLOORING	2007	780						25
26	WALLCOVERINGS	2007	17,334						26
27	CARPENTRY	2007	29,147						27
28	DOORS & FRAMES	2007	17,334						28
29	2 ROOF TOP UNITS	2007	4,885						29
30	UTILITY RM IMPROVEMENTS	2007	4,900						30
31	2 ROOF TOP UNITS	2007	6,444						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,933,623	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning:

06/01/2014 Ending: 05/31/2015

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 12F, Carried Forward		\$ 4,933,623	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	000000001982 CARPET	2008	633						2
3	000000001984 NURSE STN, ADMIN OFF, MED RM RENVSTN	2008	22,232						3
4	000000001985 NURSE STATION CABINETRY	2008	17,892						4
5	000000001986 ADJ TO NURSE STATION (#1985)	2008	333						5
6	000000001987 RENOV CORR WALLS AND KITCH CEI	2008	6,850						6
7	000000001988 2 DOOR CLOSURES AND FRAMES	2009	12,974						7
8	000000001989 WALLCOVER PAINT EMPLOYEE HALLW	2009	5,175						8
9									9
10	New Sidewalks	2009	15,500						10
11	Renov. - Interior Demo & Renovations - Corridor Renovation	2009	83,910						11
12	Renov. - Resilent Flooring - Corridor Renovation	2009	14,912						12
13	Renov. - Carpeting & Pads - Corridor Renovation	2009	8,142						13
14	Renov. - Wallcovering & Corner Guards - Corridor Renovation	2009	50,857						14
15	Water Heaters (2) BTH-300A	2009	30,010						15
16	Concrete Flooring & Replace Under Floor Water Line	2009	4,050						16
17	New Copper Water Lines	2010	12,214						17
18	Dining Rm/Therapy-Site Prep, General Contractor	2010	21,798						18
19	Dining Rm/Therapy-Soil Tesing	2010	1,845						19
20	Dining Rm/Therapy-Arch & Engineer Cost	2010	64,025						20
21	Dining Rm/Therapy-Wallcovering	2010	1,864						21
22	Trench Box and New Gas Line	2010	4,043						22
23									23
24	Concrete Pad (main entr)	2010	4,940						24
25	Normal PT Addition - Wiring & Lights	2010	1,473						25
26	Renov. - Fire Doors, 3 sets	2010	38,850						26
27	Renov. - Painting & Wallcovering	2010	6,705						27
28	Add'l Dining Rm/Therapy-Arch & Engineer Cost	2010	2,138						28
29	Flooring & VWC in shower	2011	18,813						29
30	HM Doors (2)	2011	6,953						30
31									31
32	Rooftop Unit, 3 ton	2011	8,627						32
33	Damper for Laundry Room	2011	2,574						33
34	TOTAL (lines 1 thru 33)		\$ 5,403,955	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	34

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

Facility Name & ID Number Heartland of Normal

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,403,955	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	1
2	Water Heater	2011	3,641						2
3	Rooftop Unit, 4 ton, Dining Room	2011	10,295						3
4	Sprinkler System Upgrade	2011	10,175						4
5	Recirculation Pump	2012	4,195						5
6	Lighting - Overbed (all)	2012	21,338						6
7									7
8	80' French Drainage & repair wall	2012	8,984						8
9	AC Control Board	2012	5,009						9
10	Ceiling Tile Replacement 7,200 Sq Ft	2013	32,800						10
11									11
12	Dietary Grease Trap & Tank	2013	10,523						12
13	Hot Water Heaters (3) 120 gallon	2014	42,399						13
14									14
15	Lighted Outdoor Sign 96" x 87"	2014	7,414						15
16	General Electrical Upgrades	2014	18,750						16
17	Engineering cost for new boilers, accessories, pipe modifications	2014	6,900						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)		\$ 5,586,378	\$ 118,515		\$ 118,515	\$	\$ 4,338,549	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	\$ 2,118,348	\$ 92,753	\$ 92,753	\$		\$ 1,935,427	71
72	Current Year Purchases	45,502						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			12,057	12,057			74
75	TOTALS	\$ 2,163,850	\$ 92,753	\$ 104,810	\$ 12,057		\$ 1,935,427	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,939,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 211,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 223,325	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,057	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,273,976	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.

Facility Name & ID Number Heartland of Normal

0049536

Report Period Beginning: 06/01/2014

Ending: 05/31/2015

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. _____ /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: \$ 67,786 Description: 02 Concentrators, Wheelchairs, Geri Charis, 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>3,272</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,272</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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10a	4342	hrs	\$ 184,489	216	\$ 13,080	\$ 67	4,558	\$ 197,636	1	
2	Licensed Speech and Language Development Therapist	10a	1374	hrs	58,403			21	1,374	58,424	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	5937	hrs	252,257			13,411	5,937	265,668	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				360,838		360,838	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						121,230		121,230	12	
13	Other (specify): <u>X-Ray & Lab</u>	43,3					104,203			104,203	13	
14	TOTAL				\$ 495,149	216	\$ 117,283	\$ 495,567	11,869	\$ 1,107,999	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 Normal# 0049536Report Period Beginning: 06/01/2014Ending: 05/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/2015 (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	\$ 12,291	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>645,039</u>)	1,288,001		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,857		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,305,149	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,880		13
14	Buildings, at Historical Cost	5,586,378		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,163,850		16
17	Accumulated Depreciation (book methods)	(6,273,976)		17
18	Deferred Charges	12,290,946		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>)	85,812		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,041,890	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,347,039	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 142,078	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	372,117		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,321		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		140,581		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 723,097	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,668,364		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)	\$ 1,668,364	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,391,461	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,955,578	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,347,039	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,465,203	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,465,203	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,068,034)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,068,034)	17
B. Transfers (Itemize):			
18	Change in Interdivision	558,409	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 558,409	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,955,578	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	\$ 9,430,629	1
2	Discounts and Allowances for all Levels	(4,467,223)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,963,406	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,589,332	6
7	Oxygen	1,360	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,590,692	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	689	12
13	Barber and Beauty Care	8,635	13
14	Non-Patient Meals	609	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	745,653	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	282,554	19
20	Radiology and X-Ray	15,823	20
21	Other Medical Services	43,286	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,097,249	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	<u>Misc Inc</u>	131	28
28a	<u>Purch Dis</u>	100	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 231	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,651,578	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,262,706	31
32	Health Care	4,311,985	32
33	General Administration	2,683,936	33
B. Capital Expense			
34	Ownership	1,642,144	34
C. Ancillary Expense			
35	Special Cost Centers	608,650	35
36	Provider Participation Fee	210,191	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,719,612	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,068,034)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,068,034)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,621,280	44
45	Private Pay - Net Inpatient Revenue	2,140,724	45
46	Medicare - Net Inpatient Revenue	681,105	46
47	Other-(specify) <u>Hospice</u>	131,983	47
48	Other-(specify) <u>Insurance</u>	388,314	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,963,406	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 Normal

0049536

Report Period Beginning: 06/01/2014

Ending: 05/31/2015

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	1,995	2,157	\$ 84,001	\$ 38.94	1
2	Assistant Director of Nursing	6,643	7,182	215,334	29.98	2
3	Registered Nurses	15,244	16,483	458,717	27.83	3
4	Licensed Practical Nurses	25,816	27,914	646,726	23.17	4
5	CNAs & Orderlies	79,635	86,258	1,024,596	11.88	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	14,289	15,442	656,133	42.49	7
8	Rehab/Therapy Aides	12,816	13,850	404,034	29.17	8
9	Activity Director	4,536	4,908	67,505	13.75	9
10	Activity Assistants					10
11	Social Service Workers	7,300	7,899	179,720	22.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,726	11,632	133,885	11.51	15
16	Dishwashers					16
17	Maintenance Workers	1,816	1,967	45,562	23.16	17
18	Housekeepers	12,311	13,319	159,058	11.94	18
19	Laundry	3,726	4,033	40,994	10.16	19
20	Administrator	2,080	2,080	100,555	48.34	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,685	11,586	257,972	22.27	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	3,011	3,256	46,020	14.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitalty</u>	875	947	12,661	13.37	33
34	TOTAL (lines 1 - 33)	213,504	230,913	\$ 4,533,473 *	\$ 19.63	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	25,040	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	220	11,072	10,1	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	220	\$ 36,112		49

C. CONTRACT NURSES

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

XIX. 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		
Douglas Rutter	Administrator	0	\$ 100,555	Workers' Compensation Insurance	\$ 163,501	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	67,886	Advertising: Employee Recruitment	7,659		
				FICA Taxes	330,316	Health Care Worker Background Check			
				Employee Health Insurance	224,716	(Indicate # of checks performed <u>244</u>)	7,635		
				Employee Meals		Patient Background Checks	5,400		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,332		
				Disability Payments		Association Dues	6,626		
				401 K	8,401	Advertising	81,389		
				Appreciation, Other Benefits & Marketing Adjust	(10,727)	Other Licenses & Permits	1,237		
				Tuition Program	10	Less Non-allowable Association Dues	(2,472)		
				Employee Uniforms	5,039	Less: Public Relations Expense	()		
				Home Office Allocation	33,766	Non-allowable advertising	(81,389)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
\$ 100,555				\$ 822,908		\$ 36,407			
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	
Various home off ice service - See page 18 for breakdown			\$ 485,372				Out-of-State Travel	\$	
							In-State Travel	23,872	
							Includes travel expense to the Home Office in Toledo, OH for regional meetings		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		
\$ 485,372				\$			Entertainment Expense		()
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 23,872
C. Professional Services									
Vendor/Payee	Type		Amount						
SNF Global	Legal Fees		\$ 5,635						
Michael T. Mahoney LTD	Legal Fees		120						
(Legal Fees were adjusted off via Page 5, Line 22, therefore no invoices are attached)									
Transworld Systems Inc	Collection Services		9,650						
Michael T. Mahoney LTD	Collection Services		3,140						
Healthlink Inc	Collection Services		785						
Medical Collection Group LLC	Collection Services		150						
(Collection cost was adjusted off via Page 5 A Line 3)									
Medical Collection Group LLC	Collection Services		400						
(Collection cost was adjusted off via Page 5 A Line 5)									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)									
\$ 19,880									

* Attach copy of IMRF notifications

**See instructions.

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 Normal

0049536

Report Period Beginning: 06/01/2014

Ending: 05/31/2015

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. IHCA \$2,502 & AHCA \$1,653
- (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. \$ 55,436 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. \$ 210,191
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. \$ 609
- (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.