

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0049403

Facility Name: Heartland of Moline

Address: 833 Sixteenth Avenue Moline 61265
Number City Zip Code

County: Rock Island

Telephone Number: (309) 764-6744 Fax # (309) 764-8176

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Gary Geise Telephone Number: 419-252-5731
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

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

Facility Name & ID Number Heartland of Moline# 0049403 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	<u>149</u>	Skilled (SNF)	<u>149</u>	<u>54,534</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>149</u>	TOTALS	<u>149</u>	<u>54,534</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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,508</u>	<u>22,119</u>	<u>20,558</u>	<u>46,185</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>3,508</u>	<u>22,119</u>	<u>20,558</u>	<u>46,185</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.69%

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?

YesG. 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 01/01/83

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

YES ☒Date 04/07/2011NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 118 and days of care provided 16,771Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31Fiscal Year: 12/31

* 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	290,900	26,236	68,232	385,368		385,368		385,368			1
2	Food Purchase		343,554		343,554		343,554	(2,241)	341,313			2
3	Housekeeping	212,206	14,758	930	227,894		227,894		227,894			3
4	Laundry	58,869	10,362		69,231		69,231		69,231			4
5	Heat and Other Utilities			168,957	168,957	2,517	171,474		171,474			5
6	Maintenance	51,169	5,432	71,677	128,278		128,278		128,278			6
7	Other (specify):* Medical Waste			1,536	1,536		1,536		1,536			7
8	TOTAL General Services	613,144	400,342	311,332	1,324,818	2,517	1,327,335	(2,241)	1,325,094			8
	B. Health Care and Programs											
9	Medical Director			19,013	19,013		19,013		19,013			9
10	Nursing and Medical Records	3,076,760	232,230	81,346	3,390,336	15,686	3,406,022		3,406,022			10
10a	Therapy	1,592,307	14,916	121,845	1,729,068		1,729,068		1,729,068			10a
11	Activities	113,886	3,392	3,272	120,550		120,550		120,550			11
12	Social Services	157,953	56	973	158,982		158,982		158,982			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,940,906	250,594	226,449	5,417,949	15,686	5,433,635		5,433,635			16
	C. General Administration											
17	Administrative	138,348		667,285	805,633	(326,676)	478,957		478,957			17
18	Directors Fees											18
19	Professional Services			3,482	3,482		3,482	(3,250)	232			19
20	Dues, Fees, Subscriptions & Promotions			82,236	82,236		82,236	(54,109)	28,127			20
21	Clerical & General Office Expenses	474,947	56,498	166,714	698,159		698,159	(217,859)	480,300			21
22	Employee Benefits & Payroll Taxes			1,018,684	1,018,684	48,584	1,067,268		1,067,268			22
23	Inservice Training & Education			1,391	1,391		1,391		1,391			23
24	Travel and Seminar			16,894	16,894		16,894		16,894			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			832,134	832,134		832,134		832,134			26
27	Other (specify):*							(423)	(423)			27
28	TOTAL General Administration	613,295	56,498	2,788,820	3,458,613	(278,092)	3,180,521	(275,641)	2,904,880			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,167,345	707,434	3,326,601	10,201,380	(259,889)	9,941,491	(277,882)	9,663,609			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			524,211	524,211	17,842	542,053		542,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,041,759	2,041,759	242,047	2,283,806	(2,043,026)	240,780			32
33	Real Estate Taxes			125,745	125,745		125,745		125,745			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			44,159	44,159		44,159		44,159			35
36	Other (specify):*											36
37	TOTAL Ownership			2,735,874	2,735,874	259,889	2,995,763	(2,043,026)	952,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			12,500	12,500		12,500		12,500			38
39	Ancillary Service Centers		460,351		460,351		460,351		460,351			39
40	Barber and Beauty Shops			9,845	9,845		9,845		9,845			40
41	Coffee and Gift Shops	148,911			148,911		148,911		148,911			41
42	Provider Participation Fee			405,913	405,913		405,913		405,913			42
43	Other (specify):* IV, X-ray& Lab		113,057	78,145	191,202		191,202		191,202			43
44	TOTAL Special Cost Centers	148,911	573,408	506,403	1,228,722		1,228,722		1,228,722			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,316,256	1,280,842	6,568,878	14,165,976		14,165,976	(2,320,908)	11,845,068			45

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

		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	(2,241)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(815)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(423)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,250)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(113,865)	21		24
25	Fund Raising, Advertising and Promotional	(54,109)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached pg 5A	(2,145,705)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,320,908)		\$	30

BHF USE ONLY							
48		49		50		51	52

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,320,908)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heartland of Moline

Report Period Beginning:

Ending:

ID#0049403

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (77,469)	21	1
2	P/R O/H Alloc- Mktg	(22,591)	21	2
3	HCP Lease Interest	(2,043,026)	32	3
4	Vending Income	(2,619)	21	4
5	Misc Income		21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		36	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	(2,145,705)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Moline # 0049403 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(2,241)	0	0	0	0	0	0	0	0	0	0	(2,241)	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	(2,241)	0	0	0	0	0	0	0	0	0	0	(2,241)	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	(3,250)	0	0	0	0	0	0	0	0	0	0	(3,250)	19
20	Fees, Subscriptions & Promotions	(54,109)	0	0	0	0	0	0	0	0	0	0	(54,109)	20
21	Clerical & General Office Expenses	(217,859)	0	0	0	0	0	0	0	0	0	0	(217,859)	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):*	(423)	0	0	0	0	0	0	0	0	0	0	(423)	27
28	TOTAL General Administration	(275,641)	0	0	0	0	0	0	0	0	0	0	(275,641)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(277,882)	0	0	0	0	0	0	0	0	0	0	(277,882)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(2,043,026)	0	0	0	0	0	0	0	0	0	0	(2,043,026)	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	(2,043,026)	0	0	0	0	0	0	0	0	0	0	(2,043,026)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,320,908)	0	0	0	0	0	0	0	0	0	0	(2,320,908)	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 Heath Care	Toledo	Nursing Staff
		See Pg 6 Supp for list of related nursing homes in Illinois				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	Home Office Allocation	\$ 667,285	HCR Manor Care Services, LLC	100.00%	\$ 667,285	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,316,256	Heartland Employment Services, LLC	100.00%	6,316,256		4
5	V	10a	Therapy Management	17,606	Heartland Rehab Services, LLC	100.00%	17,606		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			\$ 7,001,147			\$ 7,001,147	\$ *	14

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

Facility Name & ID Number

Heartland of Moline

0049403

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, 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								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Moline # 0049403 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	\$ 748,673	\$	13,447,247	\$ 2,517	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs			13,447,247	0	2
3	5	Utilities - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs			13,447,247	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	419,407	305,829	13,447,247	1,410	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	13,447,247	14,276	5
6	10	Nursing - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs			13,447,247	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	66,682,648	33,182,703	13,447,247	224,202	7
8	17	General & Administrative - Direct	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	13,447,247	68,726	8
9	17	General & Administrative - Direct	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,308	13,447,247	47,681	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	7,480,805		13,447,247	25,152	10
11	22	Employee Benefits - Direct to All	Accumulated Cost	3,550,656,576	354 NFs	6,187,019		13,447,247	23,432	11
12	22	Employee Benefits - Direct to Mid	Accumulated Cost	517,936,312	48 NFs			13,447,247	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	4,579,765		13,447,247	15,398	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474		13,447,247	2,444	14
15	30	Depreciation - Direct to Midwest	Accumulated Cost	517,936,312	48 NFs			13,447,247	0	15
16										16
17										17
18	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		13,447,247	86,985	18
19	32	Directly Assigned Interest	Not Allocated			18,513,013			155,062	19
20										20
21		H/O Costs Allocated to Non-SNFs and Other Divisions				30,612,518				21
22										22
23										23
24										24
25	TOTALS					\$ 185,493,068	\$ 50,996,411		\$ 667,285	25

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		2		3	4	5	6		7	8	9	10	
	Name of Lender	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	Various			Purchased Facility		10/3/1991	\$ 389,893	\$ 389,893		0.0653	\$ 25,478	1	
2	Various			Finance Capital Additions		3/07 & 11/97	972,504	972,504		0.0653	63,549	2	
3	Various			Finance Capital Additions		6/01 & 9/01	1,010,547	1,010,547		0.0653	66,035	3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										86,985	7	
8	Interest Income Other										(1,267)	8	
9	TOTAL Facility Related						\$ 2,372,944	\$ 2,372,944			\$ 240,780	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,372,944	\$ 2,372,944			\$ 240,780	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	123,767	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.)				\$	124,756	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	989	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	124,756	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.				\$	125,745	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2007	115,115	8	<table border="1"> <tr> <td></td> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	119,281	9																							
	2009	120,547	10																							
	2010	123,767	11																							
	2011	124,756	12																							

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Moline COUNTY Rock Island
FACILITY IDPH LICENSE NUMBER 0049403
CONTACT PERSON REGARDING THIS REPORT Gary Geise
TELEPHONE 419-252-5731 FAX #: 419-254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>08-533-28-00</u>	<u>See Attached</u>	\$ <u>123,522.16</u>	\$ <u>123,522.16</u>
2.	<u>08-534-05-10</u>	<u>See Attached</u>	\$ <u>1,233.60</u>	\$ <u>1,233.60</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>124,755.76</u></u>	\$ <u><u>124,755.76</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:50,742

B. General Construction Type:ExteriorMasonryFrameSteel, Fire resistant

Number of Stories1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983 & 2003	\$181,010	1
2			2006	48,251	2
3	TOTALS			\$229,261	3

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	118		1996	1996	\$ 1,033,964	\$ 89,647		\$ 89,647	\$	2,440,308	4
5				1993	56,519						5
6	11			1998	1,398,475						6
7	10 beds in 2001 & 10 beds in 2006			2001	821,410						7
8	Physical Therapy addition-general contractor			2010	267,733						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					268,365		268,365		3,535,444	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						34
35											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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Land Improvements	1995	\$ 980	\$		\$	\$	\$	37
38	Building Improvements	1995	32,598						38
39	Land Improvements: Sign, Landscatping, and Concrete Bumpers	1996	25,027						39
40	Building Improvements: Painting/Wallcovering, Carpet, Paging sy	1996	126,134						40
41	doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								41
42	hand rails,electrical wiring, ceramic tile, and bathroom sinks								42
43	Building Improvements: Fire alarm	1996	45,151						43
44	Building Improvements: Intercom system	1996	27,230						44
45	Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414						45
46	architect and engineering fees, interior design costs, drywall and								46
47	corner guards, aluminum chips, electrical heating, air conditioning								47
48	fire stop installation and access doors, and storage fees								48
49	Building Improvements: Wallcovering	1996	118,024						49
50	Building Improvements: Sewer Runs	1997	10,708						50
51	Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						51
52	door frames, millwork, carpetry, caulking, ceilings plaster,								52
53	plumbing comosite, electrical composite, sinks, conduit wiring,								53
54	door closing devices, nurses call system								54
55	Building Improvements: 18 Bed Addition, wallcovering, conncrete,	1997	334,930						55
56	doors wood, telephone system, fencing wire, electrical transformer,								56
57	HVAC, hollow metal doors, duct work								57
58	Building Improvements: Install HVAC, electrical composite	1997	291,760						58
59	Building Improvements: Roof Replacement	1997	49,483						59
60	Building Improvements: Door	1997	1,042						60
61	Building Improvements: Siding on new additon	1997	4,993						61
62	Building Improvement: VWC from Inventory	1997	1,464						62
63	Land Improvements: Sign	1997	593						63
64	Land Improvements: Landscaping	1997	801						64
65	Land Improvements: Fence	1997	5,422						65
66	Bldg. Improvements: Cupola	1998	5,440						66
67	Bldg. Improvements: HVAC	1998	23,069						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,522,732	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	70

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,522,732	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	1
2	Bldg. Improvements: Roof	1998	8,203						2
3	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						3
4	Bldg. Improvements: Add't HVAC	1998	15,464						4
5	Bldg. Improvements: 8 Bed Addition	1998	88,423						5
6	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						6
7	Land Improvements: Grading	1998	1,779						7
8	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						8
9	Bldg. Improvements: Doors	1998	10,151						9
10	Asphalt Work	1999	14,164						10
11	Smoking Shelter	1999	5,254						11
12	Overhead from Const	1999	29,447						12
13	Concrete Pad for Smoking	1999	924						13
14	Exit Device	1999	474						14
15	Carpet	1999	994						15
16	Carpet	1999	553						16
17	Awning	1999	2,788						17
18	Building Decorations	1999	653						18
19	Retainage for Carpet	1999	73						19
20	Retainage Fee for Carpet	1999	59						20
21	Wallboard	1999	568						21
22	Wiring	1999	3,850						22
23	Wall, Drain Lines, Electrica	1999	15,776						23
24	Boiler Pump	2000	5,433						24
25	HVAC Upgrade	2000	1,600						25
26	Boiler room exhaust	2000	5,684						26
27	Phone line	2000	800						27
28	Phone line	2000	800						28
29	Ceramic tile	2000	511						29
30	Carpet	2000	842						30
31	Sinks & faucet	2000	1,055						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,809,233	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,809,233	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	1
2	Add'l cost sinks	2000	218						2
3	Add'l cost carpeting	2000	59						3
4	Add'l cost carpet	2000	94						4
5	Retainer on boiler room exhaust	2000	632						5
6	Replace door in laundry	2000	4,932						6
7	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						7
8	Bldg Imprv - Carpentry/Electrical	2001	60,645						8
9	Bldg Imprv - Wallcovering	2001	11,630						9
10	Land Imprv - Concrete work	2001	4,941						10
11	Land Imprv - Walkway & Canopy	2001	3,858						11
12	Wire Component Connection	2001	2,543						12
13	Wire Component Connection	2002	327						13
14	Wire Component Connection	2002	402						14
15	Building Addition - VWC - Corridor	2002	19,847						15
16	Paint, VWC - Corridor Renovation	2001	45,377						16
17	Corner Guards	2002	7,153						17
18	Mini-Edger	2002	729						18
19	Corner Guards - Asset adjustment	2002	(4,953)						19
20	Building Addition - Paving/Landscaping	2002	8,679						20
21	Building Addition - Paving/Landscaping	2002	8,397						21
22	Building Addition - Paving/Landscaping	2002	111,907						22
23	Paving	2002	5,025						23
24	2 Dell celeron	2002	1,687						24
25	Electrical Work Overhead & Interest	2003	55,146						25
26	Overhead & Interest	2003	8,734						26
27	General Construction	2003	5,540						27
28	Carpet and Flooring	2003	83,248						28
29	Floorcovering	2003	702						29
30	Floorcovering	2003	251						30
31	HVAC	2003	7,643						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,276,159	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,276,159	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	1
2	HVAC Kitchen retainage	2003	5,627						2
3	Overhead & Interest	2003	8,231						3
4	Overhead & Interest	2003	(8,231)						4
5	Retro Cost Adjustment	2003	84,377						5
6	Retro Cost Adjustment	2003	48,938						6
7	Sealcoat & Restripe Pkg.	2004	(48,938)						7
8	Sealcoat & Restripe Pkg.	2004	2,602						8
9	VWC	2004	68						9
10	Flooring and Painting	2004	1,486						10
11	VWC & Painting	2004	1,278						11
12	Carpet	2004	472						12
13	Interest	2005	3,449						13
14	Interest	2005	(3,449)						14
15	General Overhead	2005	46,589						15
16	General Overhead	2005	(46,589)						16
17	Fire Sprinkler System	2005	142,143						17
18	EXHAUST SYSTEM	2005	7,150						18
19	condensing unit	2006	4,193						19
20	Addition - Soil Testing & Plan Reviews	2006	28,303						20
21	Addition - Site Clearing, Grading, Concrete, Treatment, & Prep	2006	25,048						21
22	Addition - Landscaping	2006	45,850						22
23	Addition - Asphalt Paving	2006	16,258						23
24	Addition - Concrete Paving & Cast Stone	2006	139,095						24
25	Addition - Sewar Replacement & Fees	2006	36,004						25
26	Addition - Permit Fees	2006	9,757						26
27	Addition - Pre Construction & Bldg. Excavation	2006	139,343						27
28	Addition - Site Utilities	2006	11,905						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,977,119	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,977,119	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	1
2	<u>Addition - General Conditions</u>	2006	115,912						2
3	<u>Addition - Carpentry-Subcontr.</u>	2006	195,647						3
4	<u>Addition - Roofing/Waterproofing</u>	2006	4,393						4
5	<u>Addition - HM Doors/Frames/Drywall/Studs</u>	2006	9,905						5
6	<u>Addition - Wood Doors</u>	2006	24,735						6
7	<u>Addition - Ceiling Tile & Flooring</u>	2006	17,927						7
8	<u>Addition - Carpet/Paint/WC/Corner Guards</u>	2006	42,687						8
9	<u>Addition - Fire Sprinkler Syster</u>	2006	19,963						9
10	<u>Addition - Plumbing</u>	2006	59,204						10
11	<u>Addition - Basic Electrical</u>	2006	108,830						11
12	<u>Addition - Archetectual & Engineering Cost</u>	2006	128,176						12
13	<u>Addition - General Overhead</u>	2006	71,933						13
14	<u>Addition - Builders Risk Insurance</u>	2006	1,100						14
15	<u>Addition - Gypsum Board System</u>	2006	62,975						15
16	<u>Addition - Masonry & Metals</u>	2006	142,412						16
17	<u>Addition - Demolition</u>	2006	13,731						17
18	<u>Renov - General Overhead</u>	2007	13,148						18
19	<u>Renov - Carpentry - Subcontractor</u>	2007	46,583						19
20	<u>Renov - Wallcovering</u>	2007	106,341						20
21	<u>Renov - Interest on Construction</u>	2007	957						21
22	<u>0807 STORMSEWERS COURTYRD</u>	2008	3,309						22
23	<u>Adj 2006 Asset Addition - Arch & Engineering Cost</u>	2008	1,765						23
24	<u>Adj 2006 Asset Addition - General Overhead</u>	2008	150						24
25	<u>Adj 2006 Asset Addition - Arch & Engineering Cost</u>	2008	1,943						25
26	<u>0807 STORMSEWERS COURTYRD</u>	2008	67,397						26
27	<u>CONCRETE SIDWALK</u>	2008	1,672						27
28									28
29	<u>Alum siding</u>	2008	4,500						29
30	<u>Door entrance closers</u>	2008	3,613						30
31	<u>alum siding</u>	2009	2,223						31
32	<u>000000090694 Safety ren-ovhead</u>	2009	3,035						32
33	<u>000000090694 Safety ren-interest</u>	2009	167						33
34	TOTAL (lines 1 thru 33)		\$ 8,253,451	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	34

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

Facility Name & ID Number Heartland of Moline

0049403

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,253,451	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	1
2	000000090695 Safey ren-carpentry	2009	13,140						2
3	000000090695 Safey ren-hm doors & frames	2009	17,553						3
4	000000090695 Safey ren-sprinklers	2009	1,228						4
5	000000090699 Cor ren-Gen ovhd capit	2009	6,495						5
6	000000090699 Cor ren-interest on const	2009	378						6
7	000000090699 Cor ren-resilient flooring	2009	95,159						7
8	000000090699 Cor ren-carpeting & pads	2009	1,342						8
9	000000090699 Cor ren-wall covering	2009	11,954						9
10	000000090699 Cor ren-cornder guards	2009	103						10
11	000000090699 Cor ren-resilient flooring	2009	123,012						11
12	000000090699 Cor ren-carpeting & pads	2009	1,162						12
13	000000090699 Cor ren-wall covering	2009	8,830						13
14	000000090704 Hollow metal door	2009	2,445						14
15	000000090705 ADJ ASSET #90699	2009	2,803						15
16	000000090706 ADJ ASSET #90699	2009	448						16
17	000000090708 vwc and ceiling tiles in	2009	13,241						17
18	000000090692 CONCRETE SIDEWALK	2008	21,279						18
19	000000090697 Grading and sub-drain til	2009	21,391						19
20									20
21	BI 090713 ADj ASSET 90699-vwc & ceiling tiles	2010	13,241						21
22	BI 090716 MOLINE PT-Arch & Eng costs	2010	84,024						22
23	BI 090717 CLSE PROJ MLNE PT MOVE-gen o/h cap	2010	17,706						23
24	BI 090721 MOLINE PT-wall covering	2010	1,310						24
25	BI 090733 ADJ ASSET #90721-wall covering	2010	2,026						25
26	BI 090738 Vestibule, front entry, seating renovation	2010	8,037						26
27	BI 090743 adj asset 90738-vestibule renovation	2010	8,037						27
28	LI 090722 MOLINE PT-general contractor	2010	157,687						28
29	LI 090723 MOLINE PT-soil & concrete testing	2010	7,645						29
30	000000090801 LAUNDRY HVAC	2012	19,810						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,914,937	\$ 358,012		\$ 358,012	\$	\$ 5,975,752	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	\$2,838,355	\$166,199	\$166,199	\$		\$2,393,236	71
72	Current Year Purchases	98,567						72
73	Fully Depreciated Assets							73
74	Home Office			17,842	17,842			74
75	TOTALS	\$2,936,922	\$166,199	\$184,041	\$17,842		\$2,393,236	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport residents	1986 Chevy van with chair lift		\$22,049	\$	\$	\$		\$22,049	76
77										77
78										78
79										79
80	TOTALS			\$22,049	\$	\$	\$		\$22,049	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)	\$12,103,169	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$524,211	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$542,053	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$17,842	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$8,391,037	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
- If NO, see instructions.

		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:	N/A			\$			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. _____/2013 \$ _____
13. _____/2014 \$ _____
14. _____/2015 \$ _____

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: \$ 18,551 Description: 02 Concentrators, wheelchairs, gerichairs, electric beds
- (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	Patient transportation	1995 & 2009 Ford Bus	\$	\$ 25,608	17
18					18
19				above figures includes	19
20				gas & maintenance too.	20
21	TOTAL		\$	\$ 25,608	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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	11544	hrs	\$ 460,722	299	\$ 17,030	\$ 543	11,843	\$ 478,295	1
2	Licensed Speech and Language Development Therapist	10a	3214	hrs	128,274			23	3,214	128,297	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	9374	hrs	374,145	211	12,043	14,350	9,585	400,538	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				460,351		460,351	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						113,057		113,057	12
13	Other (specify): X-ray & Lab	43, 3					78,145			78,145	13
14	TOTAL				\$ 963,141	510	\$ 107,218	\$ 588,324	24,642	\$ 1,658,683	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,283	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 258,314)	1,529,072		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,533,355	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,261		13
14	Buildings, at Historical Cost	8,914,935		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,958,968		16
17	Accumulated Depreciation (book methods)	(8,391,037)		17
18	Deferred Charges	30,317,848		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	31,438		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 34,061,413	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 35,594,768	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 175,340	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	477,290		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,756		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	207,049		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 984,435	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,372,944		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)	\$ 2,372,944	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,357,379	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 32,237,389	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,594,768	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,119,889	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,119,889	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,387,599	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)	\$ 1,387,599	17
	B. Transfers (Itemize):		
18	Change in Interdivision	28,729,901	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 28,729,901	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 32,237,389	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Moline# 0049403Report Period Beginning: 01/01/12Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,422,783	1
2	Discounts and Allowances for all Levels	(5,014,707)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,408,076	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,255,679	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,255,679	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	3,042	12
13	Barber and Beauty Care	9,558	13
14	Non-Patient Meals	2,241	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	519,904	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,940	19
20	Radiology and X-Ray	88,718	20
21	Other Medical Services	177,917	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 889,320	23
	D. Non-Operating Revenue		
24	Contributions	500	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 500	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,553,575	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,324,818	31
32	Health Care	5,417,949	32
33	General Administration	3,458,613	33
	B. Capital Expense		
34	Ownership	2,735,874	34
	C. Ancillary Expense		
35	Special Cost Centers	822,809	35
36	Provider Participation Fee	405,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,165,976	40
41	Income before Income Taxes (line 30 minus line 40)**	1,387,599	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,387,599	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 489,138	44
45	Private Pay - Net Inpatient Revenue	4,808,405	45
46	Medicare - Net Inpatient Revenue	4,416,104	46
47	Other-(specify) <u>Hospice</u>	2,153	47
48	Other-(specify) <u>Insurance</u>	692,276	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,408,076	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.

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	1,977	2,186	\$ 88,484	\$ 40.48	1
2	Assistant Director of Nursing	3,598	3,979	115,008	28.90	2
3	Registered Nurses	20,449	22,612	582,185	25.75	3
4	Licensed Practical Nurses	36,221	40,052	768,023	19.18	4
5	CNAs & Orderlies	105,516	116,919	1,429,777	12.23	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	24,132	26,687	1,065,130	39.91	7
8	Rehab/Therapy Aides	19,574	21,647	527,177	24.35	8
9	Activity Director	8,348	9,243	113,886	12.32	9
10	Activity Assistants					10
11	Social Service Workers	7,362	8,153	157,953	19.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,414	27,028	290,900	10.76	15
16	Dishwashers					16
17	Maintenance Workers	1,963	2,174	51,169	23.54	17
18	Housekeepers	16,475	18,240	212,206	11.63	18
19	Laundry	4,958	5,488	58,869	10.73	19
20	Administrator	2,080	2,080	114,597	55.09	20
21	Assistant Administrator	772	772	23,751	30.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,892	18,863	374,887	19.87	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	3,748	4,151	93,283	22.47	31
32	Other Health Care(specify)					32
33	Other(specify)Hospitality	9,619	10,649	148,911	13.98	33
34	TOTAL (lines 1 - 33)	308,098	340,923	\$ 6,216,196 *	\$ 18.23	34

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	19,013	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,013		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Vickie Toomsen	Administrator	0	\$ 114,597
Gaurav Patel	Asst. Administrator	0	23,751
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,348
B. Administrative - Other			
Description			Amount
Home Office Costs			\$ 667,285
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 667,285
C. Professional Services			
Vendor/Payee	Type		Amount
United Collection Bureau Inc.	Collection Services		\$ 232
Andich & Andich	Legal Fees		2,800
Littler Mendelson PC	Legal Fees		450
(All legal fees above are adjusted off via page 5, Line 22, therefore no invoices are attached)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,482
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 84,684
Unemployment Compensation Insurance			103,898
FICA Taxes			453,178
Employee Health Insurance			354,858
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Tuition Program			
Disability Payments			1,649
401K & marketing adj			10,187
Appreciation, other benefits			2,949
SMSP Company Match			1,335
Employee Uniforms			5,946
Home Office Allocation			48,584
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,067,268
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 5,220
Advertising: Employee Recruitment			6,224
Health Care Worker Background Check (Indicate # of checks performed 116)			3,489
Patient Background Checks	600		6,000
Dues & Subscriptions			2,289
Association Dues			15,877
Advertising (Allow)			4,442
Advertising (Non-All)			38,695
Less: Non-allow association dues			(10,972)
Less: Public Relations Expense			(4,442)
Non-allowable advertising			(38,695)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 28,127
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			16,894
Seminar Expense			
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 16,894

*** 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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$4905

(3) Did the nursing home make political contributions or payments to a political action organization? Yes \$10,972 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. \$ 73,999 Line 10, 2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 04/07/11

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 405,913
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. \$ 2,241

(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 out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.