

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0049544

Facility Name: Heartland of Decatur

Address: 444 West Harrison St Decatur 62526
Number City Zip Code

County: Macon

Telephone Number: (217) 877-7333 Fax # (217) 872-6723

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

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: Jeff Lewandowski Telephone Number: (419) 252-5736
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 06/01/15 to 05/31/16 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) Martin D. Allen
(Title) Director

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 Decatur

0049544 Report Period Beginning: 06/01/15 Ending: 05/31/16

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>117</u>	Skilled (SNF)	<u>117</u>	<u>42,822</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>117</u>	TOTALS	<u>117</u>	<u>42,822</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,275</u>	<u>9,649</u>	<u>7,123</u>	<u>29,047</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>12,275</u>	<u>9,649</u>	<u>7,123</u>	<u>29,047</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.83%

D. How many bed-hold days during this year were paid by the Department? _____ (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 117 and days of care provided 5,719

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 5/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	228,916	21,849	78,993	329,758		329,758		329,758			1
2	Food Purchase		244,413		244,413		244,413	(1,163)	243,250			2
3	Housekeeping	164,460	21,885	1,149	187,494		187,494		187,494			3
4	Laundry	20,066	12,700		32,766		32,766		32,766			4
5	Heat and Other Utilities			133,944	133,944	1,811	135,755		135,755			5
6	Maintenance	52,176	9,885	76,164	138,225		138,225		138,225			6
7	Other (specify):* Med Waste			5,676	5,676		5,676		5,676			7
8	TOTAL General Services	465,618	310,732	295,926	1,072,276	1,811	1,074,087	(1,163)	1,072,924			8
	B. Health Care and Programs											
9	Medical Director			43,200	43,200		43,200		43,200			9
10	Nursing and Medical Records	2,284,913	182,664	132,791	2,600,368	6,078	2,606,446		2,606,446			10
10a	Therapy	752,301	7,484	89,171	848,956		848,956		848,956			10a
11	Activities	88,265	3,211	2,201	93,677		93,677	(152)	93,525			11
12	Social Services	125,635	3,570	3,491	132,696		132,696		132,696			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,251,114	196,929	270,854	3,718,897	6,078	3,724,975	(152)	3,724,823			16
	C. General Administration											
17	Administrative	71,087		429,980	501,067	(160,504)	340,563		340,563			17
18	Directors Fees											18
19	Professional Services			78,469	78,469		78,469	(78,469)				19
20	Dues, Fees, Subscriptions & Promotions			105,158	105,158		105,158	(30,578)	74,580			20
21	Clerical & General Office Expenses	360,375	36,214	300,141	696,730		696,730	(187,884)	508,846			21
22	Employee Benefits & Payroll Taxes			695,193	695,193	27,244	722,437		722,437			22
23	Inservice Training & Education			3,476	3,476		3,476		3,476			23
24	Travel and Seminar			32,483	32,483		32,483		32,483			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			170,401	170,401		170,401		170,401			26
27	Other (specify):*							(1,800)	(1,800)			27
28	TOTAL General Administration	431,462	36,214	1,815,301	2,282,977	(133,260)	2,149,717	(298,731)	1,850,986			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,148,194	543,875	2,382,081	7,074,150	(125,371)	6,948,779	(300,046)	6,648,733			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			221,117	221,117	9,277	230,394		230,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			509,937	509,937	116,094	626,031	(520,470)	105,561			32
33	Real Estate Taxes			101,865	101,865		101,865		101,865			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,931	49,931		49,931		49,931			35
36	Other (specify):*											36
37	TOTAL Ownership			882,850	882,850	125,371	1,008,221	(520,470)	487,751			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,867	1,200	210,067		210,067		210,067			39
40	Barber and Beauty Shops			11,725	11,725		11,725		11,725			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			190,600	190,600		190,600		190,600			42
43	Other (specify):* IV X-Ray & Lab		(13,630)	21,058	7,428		7,428		7,428			43
44	TOTAL Special Cost Centers		195,237	224,583	419,820		419,820		419,820			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,148,194	739,112	3,489,514	8,376,820		8,376,820	(820,516)	7,556,304			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,163)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(659)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(402)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,800)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(56,508)	21		18
19	Entertainment				19
20	Contributions	(1,576)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(67,713)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(125,803)	21		24
25	Fund Raising, Advertising and Promotional	(30,578)	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	(534,314)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (820,516)		\$	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 Amount	2 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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (820,516)		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 Yes	2 No	3 Amount	4 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		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ (152)	11	1
2	Misc. Income		21	2
3	Vending Income	(1,436)	21	3
4	Donations Revenue	(1,500)	21	4
5	Accounting/Collection Fees	(10,756)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(520,470)	32	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	(534,314)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	(1,163)	0	0	0	0	0	0	0	0	0	0	(1,163)	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	(1,163)	0	0	0	0	0	0	0	0	0	0	(1,163)	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	(152)	0	0	0	0	0	0	0	0	0	0	(152)	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	(152)	0	0	0	0	0	0	0	0	0	0	(152)	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	(78,469)	0	0	0	0	0	0	0	0	0	0	(78,469)	19
20	Fees, Subscriptions & Promotions	(30,578)	0	0	0	0	0	0	0	0	0	0	(30,578)	20
21	Clerical & General Office Expenses	(187,884)	0	0	0	0	0	0	0	0	0	0	(187,884)	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):*	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800)	27
28	TOTAL General Administration	(298,731)	0	0	0	0	0	0	0	0	0	0	(298,731)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(300,046)	0	0	0	0	0	0	0	0	0	0	(300,046)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	(520,470)	0	0	0	0	0	0	0	0	0	0	(520,470)	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	(520,470)	0	0	0	0	0	0	0	0	0	0	(520,470)	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)	(820,516)	0	0	0	0	0	0	0	0	0	0	(820,516)	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 Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 360,759	HCR Manor Care Services, LLC	100.00%	\$ 360,759	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,148,194	Heartland Employment Services, LLC	100.00%	4,148,194		4
5	V	10a	Therapy Management	13,572	Heartland Rehabilitation Services, LLC	100.00%	13,572		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			\$ 4,522,525			\$ 4,522,525	\$ *	14

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

Facility Name & ID Number

Heartland of Decatur

0049544

Report Period Beginning:

06/01/15

Ending:

05/31/16

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								1
2			Heartland of Canton IL, LLC	Canton				2
3			Heartland of Champaign IL, LLC	Champaign				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 Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care 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 (East) 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

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

Facility Name & ID Number Heartland of Decatur # 0049544 Report Period Beginning: 06/01/15 Ending: 05/31/16

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 Decatur# 0049544

Report Period Beginning:

06/01/15Ending: 05/31/16

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	3,924,650,842	559 NFs, HHs, & Re	\$ 818,127	\$	8,686,654	\$ 1,811	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs			8,686,654	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			8,686,654	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	8,686,654	697	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	8,686,654	5,381	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			8,686,654	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	8,686,654	133,395	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	8,686,654	36,375	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		8,686,654	30,486	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		8,686,654	11,522	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		8,686,654	15,722	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			8,686,654	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		8,686,654	7,514	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		8,686,654	1,763	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			8,686,654	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		8,686,654	62,808	22
23	32	Directly Assigned Interest	Not Allocated			18,868,647			53,286	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797				24
25	TOTALS					\$ 177,277,351	\$ 35,285,370		\$ 360,759	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	Conv. Sub. Debentures		X				\$ 738,560	\$ 705,679		0.0755	\$ 53,286	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										62,808	7	
8	Interest Expense / Interest Income										(10,533)	8	
9	TOTAL Facility Related						\$ 738,560	\$ 705,679			\$ 105,561	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 738,560	\$ 705,679			\$ 105,561	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.)

FACILITY NAME Heartland of Decatur COUNTY Macon
FACILITY IDPH LICENSE NUMBER 0049544
CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski
TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

Enter the tax index number and real estate tax assessed for 2015 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 2015.

B. Real Estate Tax Cost Allocations

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.)

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.

A. Square Feet: 37,542

B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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		1981, 2005/06	\$ 411,449	1
2			2009	45,126	2
3	TOTALS			\$ 456,575	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	84			1963	\$ 659,655	\$ 53,336		\$ 53,336	\$	2,515,480	4
5	10			2002	480,558						5
6	23			2005	1,072,957						6
7	7/1/06 Capital Rate Adj #1			2005	259,992						7
8	Therapy Addition			2009	743,129						8
	Improvement Type**										
9	Current Year Depreciation					100,770		100,770		2,609,378	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15	RETIREMENTS			1987	(86,079)						15
16				1988	38,377						16
17				1989	18,196						17
18				1990	6,261						18
19				1991	162,665						19
20	RETIREMENTS			1991	(3,037)						20
21				1992	121,887						21
22	RETIREMENTS			1992	(6,084)						22
23				1993	191,712						23
24				1994	75,641						24
25	Consolidated 1995 Assets			1995	113,891						25
26	Consolidated 1996 Assets			1996	49,186						26
27	Consolidated 1997 Assets			1997	69,918						27
28	Consolidated 1998 Assets			1998	168,373						28
29	Consolidated 1999 Assets			1999	34,171						29
30	Consolidated 2000 Assets			2000	122,059						30
31	Consolidated 2001 Assets			2001	106,737						31
32	Consolidated 2002 Assets			2002	107,434						32
33											33
34											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

Facility Name & ID Number Heartland of Decatur

0049544

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	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 Renovation-Roofing & Sheet Metal	2003	\$ 67,148	\$		\$	\$	\$	37
38 Renovation-General Overhead	2003	1,031						38
39 7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						39
40 Renovation-Interest	2003	581						40
41 7/1/06 CAPITAL RATE ADJ #4	2003	(581)						41
42 AWNING	2003	2,470						42
43 Landscaping-Install Façade Materials	2003	23,984						43
44 GAZEBO	2003	6,215						44
45 ADD'L COST GAZEBO	2003	2,611						45
46 Renovation-Engineering	2004	4,880						46
47 Renovation-General Overhead	2004	10,453						47
48 7/1/06 Capital Rate Adj #5	2004	(10,453)						48
49 Renovation-Interest	2004	138						49
50 7/1/06 Capital Rate Adj #6	2004	(138)						50
51 Doors and Downspouts	2004	7,110						51
52 Doors Retainage	2004	790						52
53 Vinyl Tile and Cove Base	2004	17,910						53
54 Vinyl Tile and Base	2005	2,974						54
55 7/1/06 Capital Rate Adj #7	2005	(2,974)						55
56 Vinyl Tile	2005	2,974						56
57 7/1/06 Capital Rate Adj #7	2005	(2,974)						57
58 Vinyl Tile and Cove Base	2005	10,985						58
59 Water/Sewer/Utilities	2005	76,296						59
60 7/1/06 Capital Rate Adj #8	2005	(76,296)						60
61 Paving/Parking	2005	45,064						61
62 7/1/06 Capital Rate Adj #9	2005	(45,064)						62
63 Site Concrete	2005	20,963						63
64 7/1/06 Capital Rate Adj #10	2005	(20,963)						64
65 Site Preparation	2005	50,580						65
66 7/1/06 Capital Rate Adj #11	2005	(50,580)						66
67 Fencing/Gazebo/Courtyard	2005	13,234						67
68 7/1/06 Capital Rate Adj #12	2005	(13,234)						68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,865,892	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	70

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

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0049544

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,865,892	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	1
2	Landscaping	2005	30,808						2
3	7/1/06 Capital Rate Adj #13	2005	(30,808)						3
4	Site Demolition	2005	25,400						4
5	7/1/06 Capital Rate Adj #17	2005	(25,400)						5
6	Water/Sewer Testing	2005	9,025						6
7	Landscaping	2005	10,269						7
8	7/1/06 Capital Rate Adj #14	2005	(10,269)						8
9	Landscaping	2005	1,838						9
10	7/1/06 Capital Rate Adj #15	2005	(1,838)						10
11	Nursing Station Carpentry	2005	3,360						11
12	Vinyl Wall Covering	2005	1,344						12
13	Architect & Engineering Fees	2005	150,302						13
14	7/1/06 Capital Rate Adj #18	2005	(13,833)						14
15	General Overhead & Interest	2005	221,331						15
16	7/1/06 Capital Rate Adj #19	2005	(221,331)						16
17	Permit Fees, Plan Reviews	2005	15,128						17
18	7/1/06 Capital Rate Adj #16	2005	(9,600)						18
19	Vinyl Wall Covering, Flooring	2005	34,342						19
20	Vinyl Wall Covering	2005	1,551						20
21	Carpet	2005	3,680						21
22	Canopy Sprinklers	2005	3,950						22
23	Blinds	2005	2,375						23
24	Vinyl Wall Covering	2005	(676)						24
25	Fabrics	2005	498						25
26	Flooring	2005	14,253						26
27	Overhead & Interest	2005	1,641						27
28	7/1/06 Capital Rate Adj #20	2005	(1,641)						28
29	Carpentry	2005	26,507						29
30	Doors	2006	624						30
31	HVAC	2006	5,715						31
32	Painting	2006	16,890						32
33	Rooftop Unit	2006	2,325						33
34	TOTAL (lines 1 thru 33)		\$ 5,133,652	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	34

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

Facility Name & ID Number Heartland of Decatur

0049544

Report Period Beginning:

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05/31/16

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		\$ 5,133,652	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	1
2	<u>Rooftop Unit</u>	2006	10,910						2
3	<u>Demolish & Reinstall Floors</u>	2006	30,700						3
4	<u>Ductwork</u>	2006	1,163						4
5	<u>Electrical</u>	2006	4,176						5
6	<u>Wallcovering, Painting</u>	2006	2,187						6
7	<u>Fence</u>	2006	9,983						7
8	<u>ENGINEERING FOR ENTRANCE</u>	2007	1,425						8
9	<u>EXTERIOR SIGN</u>	2008	4,344						9
10	<u>SEWER LINE</u>	2008	707						10
11	<u>SEWER LINE</u>	2008	6,364						11
12	<u>0407 RESI RM CORR OFFICE RENO</u>	2008	7,619						12
13	<u>0407 RESI RM CORR OFFICE RENO</u>	2008	39,580						13
14	<u>3 TON UNIT</u>	2008	4,358						14
15	<u>100 AMP PANEL</u>	2008	1,986						15
16	<u>ADJ HOT WATER SYS (ASSET 1903)</u>	2008	7,947						16
17	<u>1308 2 HOT WATER SYSTEM</u>	2008	2,078						17
18	<u>1308 2 HOT WATER SYSTEM</u>	2008	302						18
19	<u>1308 2 HOT WATER SYSTEM</u>	2008	73,200						19
20	<u>PT, BLD IM - ARCH, ENG & DEV COSTS</u>	2009	120,617						20
21	<u>PT, BLD IM - DEV GENL O-H</u>	2009	54,958						21
22	<u>PT, BLD IM - INT ON CONSTRUCTION</u>	2009	13,277						22
23	<u>PT, BLD IM - CARPET & PADS</u>	2009	1,847						23
24	<u>PT, BLD IM - WALL COVERINGS</u>	2009	7,844						24
25	<u>RETAINING WALL</u>	2008	2,900						25
26	<u>PAVING/SEALCOATING</u>	2008	6,210						26
27	<u>PT, LI - DEV COSTS</u>	2009	44,176						27
28	<u>PT, LI - GEN'L CONTRACTOR</u>	2009	116,991						28
29	<u>PT Addition - GEN'L CONTRACTOR</u>	2009	13,771						29
30	<u>PT Addition - Arch & Eng. Costs</u>	2009	3,719						30
31	<u>PT Addition - Wallcovering & Guards</u>	2009	583						31
32	<u>PT Addition - Electrical</u>	2009	7,390						32
33	<u>PT Addition - Arch & Eng. Costs</u>	2009	962						33
34	TOTAL (lines 1 thru 33)		\$ 5,737,926	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	34

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

Facility Name & ID Number Heartland of Decatur

0049544

Report Period Beginning:

06/01/15

Ending:

05/31/16

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		\$ 5,737,926	\$ 154,106		\$ 154,106		\$ 5,124,858	1
2	Fire proof Mechanical room ceiling	2010	8,881						2
3	Carpet (6 private rooms. 123, 152, 160-163)	2010	6,879						3
4	Wallcovering & Paint (Dining Rm, Main Shower, Resident Rms.)	2010	23,000						4
5	Heating element for roof top unit	2011	1,661						5
6	Replace 110 receptacles (electric outlets) in resident rooms	2011	6,050						6
7	Replace concrete walk in court yard	2011	4,230						7
8									8
9	Awning on front of building	2012	2,055						9
10	Metal Door	2012	2,715						10
11									11
12	Build closets/shelves in Dinning & Activities Rooms	2013	23,612						12
13	Doors(5) and Closers(15) for resident rooms	2013	23,194						13
14	Parking Addition, 18 spaces - Concrete	2013	94,060						14
15	Light fixture upgrade - whole building	2014	15,631						15
16	Pavilion Structure	2014	10,933						16
17	2 SINK PLUMBING for new kidney dialysis room	2013	6,455						17
18	85 Gal H/W Tank Upgrade	2014	29,602						18
19									19
20	install video intercom @ nurses stations 1 - 2, front, reception & arcadia doors.								20
21	Install securecare @ SVC corridor	2014	14,332						21
22	emergency pwr @ empl exit, sunnyside dining, patio gate, front/back nurses stations								22
23	back/front med rm, admin, PR, DON ofcs, & Phone rm	2015	18,356						23
24									24
25	PAINT-dining rm & res rm baths	2015	14,116						25
26	renov- painting, carpeting & pads, wallcovering in lobby/vestibule, front/back nurse's								26
27	stations, and all hallways throught bldg	2015	108,840						27
28	Data Drop	2015	1,157						28
29	renovation - resilient flooring in lobby/vestibule, front/back nurse's								29
30	stations, and all hallways throught bldg	2015	137,286						30
31	repair collapsed sewer & water lines to bldg	2015	15,685						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,306,653	\$ 154,106		\$ 154,106		\$ 5,124,858	34

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

Facility Name & ID Number Heartland of Decatur

0049544

Report Period Beginning:

06/01/15

Ending:

05/31/16

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 12D, Carried Forward		\$ 6,306,653	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	1
2	Renovation - Wallcovering & Corner Guards	2015	49,729						2
3	Security Cameras @ front & back nurses stations	2015	5,115						3
4	Life Safety Corrections for Generator: new 100 amp main breaker in ancillary storage rm, run conduit to LS panel								4
5	from transfer switch outside of boiler rm. Fire stop	2015	19,200						5
6	repair/replce 6'x6' area of water damaged kitchen ceiling	2015	2,650						6
7	PAINT 14 baths: 106, 108, 111-114, 166, 161-162, 151, 145, 122, 120, 124								7
8	& 2 resident rms: 166 & 168	2016	4,100						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,387,447	\$ 154,106		\$ 154,106	\$	\$ 5,124,858	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	\$2,054,280	\$67,011	\$67,011	\$		\$1,857,393	71
72	Current Year Purchases	67,940						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			9,277	9,277			74
75	TOTALS	\$2,122,220	\$67,011	\$76,288	\$9,277		\$1,857,393	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)	\$8,966,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$221,117	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$230,394	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,277	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,982,251	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: *

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 49,931 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

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

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

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

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)	\$			

- (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.

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	

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	2454	hrs	\$ 111,560	575	\$ 38,976	\$ 142	3,029	\$ 150,678	1	
2	Licensed Speech and Language Development Therapist	10a	1623	hrs	73,781			420	1,623	74,201	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	3932	hrs	178,722	298	20,209	6,922	4,230	205,853	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				208,867		208,867	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): Inhalation Therapist	10a, 3				442	29,986		442	29,986	12	
13	Other (specify): IV Therapy/X-Ray/Lab	43, 2 & 3					21,058	(13,630)		7,428	13	
14	TOTAL				\$ 364,063	1,315	\$ 110,229	\$ 202,721	9,324	\$ 677,013	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	\$ 14,936	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (401,881))	630,488		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(351)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 645,073	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,575		13
14	Buildings, at Historical Cost	6,387,447		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,122,220		16
17	Accumulated Depreciation (book methods)	(6,982,251)		17
18	Deferred Charges	6,363,068		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) OMIT	75,076		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,422,135	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,067,208	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 148,157	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,201		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,697		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	140,074		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 694,129	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	705,679		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)	\$ 705,679	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,399,808	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,667,400	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,067,208	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,166,459	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,166,459	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,001,169)	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)	\$ (1,001,169)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	502,110	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 502,110	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,667,400	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Decatur

0049544

Report Period Beginning: 06/01/15

Ending:

05/31/16

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	\$ 7,512,604	1
2	Discounts and Allowances for all Levels	(2,758,344)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,754,260	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,154,412	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,154,412	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	3,236	12
13	Barber and Beauty Care	11,161	13
14	Non-Patient Meals	1,163	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	395,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,776	19
20	Radiology and X-Ray	4,981	20
21	Other Medical Services	25,905	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 464,668	23
	D. Non-Operating Revenue		
24	Contributions	1,500	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,500	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount & Activity Income	811	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 811	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,375,651	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,072,276	31
32	Health Care	3,718,897	32
33	General Administration	2,282,977	33
	B. Capital Expense		
34	Ownership	882,850	34
	C. Ancillary Expense		
35	Special Cost Centers	229,220	35
36	Provider Participation Fee	190,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,376,820	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,001,169)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,001,169)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,743,295	44
45	Private Pay - Net Inpatient Revenue	2,260,702	45
46	Medicare - Net Inpatient Revenue	659,653	46
47	Other-(specify) <u>Hospice</u>	15,604	47
48	Other-(specify) <u>Insurance</u>	75,006	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,754,260	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	2,124	2,261	\$ 93,852	\$ 41.51	1
2	Assistant Director of Nursing	4,307	4,585	139,547	30.44	2
3	Registered Nurses	14,382	15,308	451,851	29.52	3
4	Licensed Practical Nurses	26,199	27,886	618,873	22.19	4
5	CNAs & Orderlies	70,078	74,722	960,127	12.85	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	10,604	11,281	512,822	45.46	7
8	Rehab/Therapy Aides	7,788	8,285	239,479	28.91	8
9	Activity Director	6,547	6,978	88,265	12.65	9
10	Activity Assistants					10
11	Social Service Workers	6,223	6,629	125,635	18.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,270	20,532	228,916	11.15	15
16	Dishwashers					16
17	Maintenance Workers	2,177	2,313	52,176	22.56	17
18	Housekeepers	13,682	14,580	164,460	11.28	18
19	Laundry	1,779	1,893	20,066	10.60	19
20	Administrator	2,080	2,080	71,087	34.18	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,215	15,065	360,375	23.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,398	1,489	20,663	13.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,853	215,887	\$ 4,148,194 *	\$ 19.21	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	43,200	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)		\$ 43,200		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
Glenn Miller	Administrator	0	\$ 16,609
Monica Bessinger	Administrator	0	54,478
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,087
B. Administrative - Other			
Description			Amount
Various Home Office Services - See Page 8 for breakdown		\$	360,759
PS Admin - Norm Gross			34,697
PS Admin - Tracy Skaer-Henry			34,524
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 429,980
C. Professional Services			
Vendor/Payee	Type		Amount
Anspach Meeks Ellenberger LLP	Legal Fees	\$	69
Littler Mendelson PC	Legal Fees		37,166
Polsinelli Shughart PC	Legal Fees		104
SNF Global	Legal Fees		30,374
(Legal Fess were adjusted off via Page 5, Line 22; therefore no invoices are attached)			
Healthlink Inc	Collection Services		367
Medical Collection Group LLC	Collection Services		850
Michael T. Mahoney LTD	Collection Services		7,423
National Eligibility Solutions LLC	Collection Services		120
Transworld Systems Inc	Collection Services		1,996
(Collection Costs were adjusted off via Page 5a, Line 5)			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 78,469
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	29,825
Unemployment Compensation Insurance			59,415
FICA Taxes			305,301
Employee Health Insurance			282,236
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Disability Payments			
401K			8,296
Appreciation, Oth Benefits & Mktg Adj			(6,063)
Tuition Program			
SMSP Match			115
Employee Uniforms			16,068
Home Office Allocation			27,244
TOTAL (agree to Schedule V, line 22, col.8)			\$ 722,437
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		\$	1,990
Advertising: Employee Recruitment			43,059
Health Care Worker Background Check (Indicate # of checks performed)	206		4,804
Patient Background Checks	463		4,630
Dues & Subscriptions			18,011
Association Dues			2,335
Advertising			627,020
Other Licensessand Permits			2,142
Less: Non-Allowable Association Dues			(2,391)
Less: Public Relations Expense		(	)
Non-allowable advertising			(627,020)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 74,580
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Includes travel expense to the Home Office in Toledo, OH for regional meetings			32,483
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	32,483

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount. YES
ICHA \$2,891 & ACHA \$1,665
- (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?
What was the average life used for new equipment added during this period? YES
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. \$ 50,984 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. \$ 190,600
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. \$ 1,163
- (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