FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049460

Facility Name: Heartland of Galesburg

Address: 280 East Losey Street (Number) | Galesburg (City) | 61401 (Zip Code)

County: Knox

Telephone Number: (309) 343-2166 **Fax #** (309) 343-3289

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1964

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/2010 to 12/31/2010 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)
(Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed)
(Date)
(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 Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	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	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,206	6,321	10,467	25,994	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,206	6,321	10,467	25,994	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.78%

D. How many bed-hold days during this year were paid by the Department?
5 (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)
N/A

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 5,622

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

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

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,221	21,307	16,471	219,999	4,538	224,537		224,537			1
2	Food Purchase		199,907		199,907		199,907	(25,088)	174,819			2
3	Housekeeping	122,211	19,454	1,956	143,621		143,621		143,621			3
4	Laundry	34,584	12,214	8,690	55,488		55,488		55,488			4
5	Heat and Other Utilities			125,050	125,050	1,223	126,273		126,273			5
6	Maintenance	39,581	13,596	81,699	134,876		134,876		134,876			6
7	Other (specify):* Medical Waste			418	418		418		418			7
8	TOTAL General Services	378,597	266,478	234,284	879,359	5,761	885,120	(25,088)	860,032			8
	B. Health Care and Programs											
9	Medical Director			21,180	21,180		21,180		21,180			9
10	Nursing and Medical Records	1,432,071	160,969	96,633	1,689,673	5,382	1,695,055		1,695,055			10
10a	Therapy	478,248	2,948	53,501	534,697		534,697		534,697			10a
11	Activities	37,361	2,521	3,097	42,979		42,979		42,979			11
12	Social Services	108,164		1,841	110,005		110,005		110,005			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,055,844	166,438	176,252	2,398,534	5,382	2,403,916		2,403,916			16
	C. General Administration											
17	Administrative	76,564		275,898	352,462	(82,337)	270,125		270,125			17
18	Directors Fees											18
19	Professional Services			5,017	5,017		5,017	(4,795)	222			19
20	Dues, Fees, Subscriptions & Promotions			59,401	59,401		59,401	(39,975)	19,426			20
21	Clerical & General Office Expenses	222,107	36,026	87,700	345,833		345,833	(44,836)	300,997			21
22	Employee Benefits & Payroll Taxes			511,865	511,865	20,673	532,538		532,538			22
23	Inservice Training & Education			1,979	1,979		1,979		1,979			23
24	Travel and Seminar			8,695	8,695		8,695		8,695			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			249,082	249,082		249,082		249,082			26
27	Other (specify):*											27
28	TOTAL General Administration	298,671	36,026	1,199,637	1,534,334	(61,664)	1,472,670	(89,606)	1,383,064			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,733,112	468,942	1,610,173	4,812,227	(50,521)	4,761,706	(114,694)	4,647,012			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland of Galesburg #0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			202,996	202,996	7,167	210,163		210,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,561)	(1,561)	43,354	41,793		41,793			32
33	Real Estate Taxes			85,519	85,519		85,519		85,519			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,326	35,326		35,326		35,326			35
36	Other (specify):*											36
37	TOTAL Ownership			322,280	322,280	50,521	372,801		372,801			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,142	3,142		3,142		3,142			38
39	Ancillary Service Centers		205,744	7	205,751		205,751		205,751			39
40	Barber and Beauty Shops			9,089	9,089		9,089		9,089			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):* IV, x-ray & lab		17,291	25,352	42,643		42,643		42,643			43
44	TOTAL Special Cost Centers		223,035	83,580	306,615		306,615		306,615			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,733,112	691,977	2,016,033	5,441,122		5,441,122	(114,694)	5,326,428			45

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(25,088)	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		4		8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(241)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,795)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,979)	21		24
25	Fund Raising, Advertising and Promotional	(39,975)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Pg 5A	(616)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,694)		$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (114,694)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Heartland of Galesburg

ID# **0049460**

Report Period Beginning: **01/01/2010**

Ending: **12/31/2010**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (616)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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**	(616)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Galesburg # 0049460 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,088)	0	0	0	0	0	0	0	0	0	0	(25,088)	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**	(25,088)	0	0	0	0	0	0	0	0	0	0	(25,088)	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	(4,795)	0	0	0	0	0	0	0	0	0	0	(4,795)	19
20	Fees, Subscriptions & Promotions	(39,975)	0	0	0	0	0	0	0	0	0	0	(39,975)	20
21	Clerical & General Office Expenses	(44,836)	0	0	0	0	0	0	0	0	0	0	(44,836)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(89,606)	0	0	0	0	0	0	0	0	0	0	(89,606)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,694)	0	0	0	0	0	0	0	0	0	0	(114,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Galesburg # 0049460 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(114,694)	0	0	0	0	0	0	0	0	0	0	(114,694)	45

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, Inc	100	Health Care & Retirement Corporation of America (see H.O. Cost Report)	Toledo, OH			

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 275,898	HCR Manor care, Inc	100.00%	$ 275,898	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	8,680	Heartland Rehab Servicces, LLC	100.00%	8,680		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 284,578			$ 284,578	$ *	14

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	$ 2,652,139	$ 1,448,591	4,991,410	$ 4,538	1
2	1	Dietary - Direct to Central Div SN	Accumulated Cost	692,663,974	92 NFs			4,991,410	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Rehab			4,991,410	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs			4,991,410	0	4
5	5	Utilities - Direct to Central Div SN	Accumulated Cost	692,663,974	92 NFs			4,991,410	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551		4,991,410	1,223	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	4,991,410	4,619	7
8	10	Nursing - Direct to Central Div SN	Accumulated Cost	692,663,974	92 NFs			4,991,410	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	4,991,410	763	9
10	17	Gen & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	4,991,410	42,331	10
11	17	Gen & Admin - Direct to Central I	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	4,991,410	13,484	11
12	17	Gen & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	4,991,410	137,746	12
13	22	Emp Benefits- Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309		4,991,410	12,474	13
14	22	Emp Benefits - Direct to Central D	Accumulated Cost	692,663,974	92 NFs			4,991,410	0	14
15	22	Emp Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146		4,991,410	8,199	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954		4,991,410	489	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	692,663,974	92 NFs			4,991,410	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801		4,991,410	6,678	18
19										19
20	32	Interest				12,736,052			43,354	20
21		Non Central Div Nsg Hm Allocations				29,513,406				21
22										22
23										23
24										24
25	TOTALS					$ 185,111,177	$ 62,809,840		$ 275,898	25

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub Debentures		X	Facility			$ 964,387	$ 964,387		4.4955	$ 43,354	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(1,561)	8
9	TOTAL Facility Related						$ 964,387	$ 964,387			$ 41,793	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 964,387	$ 964,387			$ 41,793	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 & ID Number Heartland of Galesburg **#** 0049460 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	81,933	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.)	$	83,726	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,793	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	83,726	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.	$	85,519	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	66,523	8
2006	79,664	9
2007	79,998	10
2008	81,933	11
2009	81,933	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049460

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-10-427-018	See Attached	$ 41,863.12	$ 41,863.12
2.	99-10-427-018	See Attached	$ 41,863.12	$ 41,863.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,726.24	$ 83,726.24

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,388 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983 & 2003	$ 121,935	1
2	Facility		2006	47,025	2
3	TOTALS			$ 168,960	3

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1964	1964	$ 407,801	$ 35,390		$ 35,390	$	$ 616,037	4
5	7			2003	570,110						5
6	7/1/06 Capital Rate Adj #1			2003	81,936						6
7	8			2005	637,826						7
8	7/1/06 Capital Rate Adj #14			2005	125,742						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					84,510		84,510		1,664,519	9
10	Building Improvements			1968	73						10
11	Building Improvements			1969	1,059						11
12	Building Improvements			1970	1,083						12
13	Building Improvements			1971	10,602						13
14	Building Improvements			1972	5,946						14
15	Building Improvements			1973	758						15
16	Building Improvements			1974	817						16
17	Building Improvements			1975	3,645						17
18	Building Improvements			1978	19,333						18
19	Land Improvements			1983	1,350						19
20	Building Improvements			1984	21,913						20
21	Building Improvements			1985	42,479						21
22	Land Improvements			1985	8,457						22
23	Building Improvements			1986	23,347						23
24	Land Improvements			1986	2,349						24
25	Building Improvements			1987	19,172						25
26	Building Improvements			1988	14,265						26
27	Land Improvements			1988	1,470						27
28	Building Improvements			1989	36,615						28
29	Land Improvements			1990	1,500						29
30	Building Improvements			1990	27,793						30
31	Building Improvements			1991	9,501						31
32	Building Improvements			1992	24,536						32
33	Building Improvements			1993	16,600						33
34	Land Improvements			1994	3,095						34
35	Building Improvements			1994	1,278						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 Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Land Improvements	1995	$ 1,098	$		$	$	$	37
38	Building Improvements	1995	14,214						38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693						39
40	engineering fees, demolition, masonary, concrete, drywall,								40
41	windows, doors, wood trim, paint, counter tops, electrical								41
42	Building Improvements : Wallcovering	1996	79,684						42
43	Building Improvements : Carpet and vinyl	1996	33,131						43
44	Builidng Improvements : Ceramic flooring	1996	40,886						44
45	Building Improvements : Millwork	1996	25,990						45
46	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45 (1996)	1996	(627)						46
47	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580						47
48	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								48
49	vinyl flooring								49
50	Building Improvements : Doors	1997	10,728						50
51	Building Improvements : Electrical composite, automatic doors,	1997	38,947						51
52	metal doors, fire alarm system								52
53	Building Improvements : Capalo	1997	2,500						53
54	Building Improvements : Generator	1997	7,743						54
55	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						55
56	Building Improvements : Onan Genator	1997	17,482						56
57	Building Improvements : Soffits, gutters & trim	1997	9,962						57
58	Building Improvements : Generator	1997	24,885						58
59	Building Improvements - HVAC	1997	42,499						59
60	Land Improvements - Sidewald	1998	7,988						60
61	Building Improvements - Fire Prevention System	1998	35,013						61
62	Sidewalk	1999	7,988						62
63	Sidewalk	1999	900						63
64	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	1999	(900)						64
65	Overhead from const	1999	2,681						65
66	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	1999	(2,681)						66
67	Power control wiring for ne	1999	2,392						67
68	Sprinkler system upgrade	1999	19,107						68
69	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	1999	(1,740)						69
70	TOTAL (lines 4 thru 69)		$ 3,084,150	$ 119,900		$ 119,900	$	$ 2,280,556	70

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,084,150	$ 119,900		$ 119,900	$	$ 2,280,556	1
2	Air compressor	1999	598						2
3	Laundry room floor	1999	1,800						3
4	Sprinkler upgrade	1999	23,940						4
5	Fire sprinkler system	1999	2,971						5
6	Boiler	1999	33,600						6
7	HVAC upgrade	1999	2,420						7
8	Building improvements	1999	1,200						8
9	SMOKING HUT	2000	4,950						9
10	CONCRETE FOR SMOKE HUT	2000	350						10
11	CABINETRY	2000	3,690						11
12	ELECTRICAL	2000	20,205						12
13	ADDT'L COST SMOKING HUT	2000	645						13
14	ELECTRICAL	2000	10,880						14
15	ELECTRICAL	2000	3,454						15
16	HVAC	2000	21,662						16
17	ELECTRICAL/NEW OFFICE	2000	860						17
18	CABINETS	2000	1,369						18
19	HVAC	2000	1,736						19
20	HVAC	2000	193						20
21	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						21
22	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2000	(15,146)						22
23	AIR / HUMIDIFIER COIL	2001	5,233						23
24	CANOPY	2001	1,200						24
25	CONCRETE PATIO	2001	5,500						25
26	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						26
27	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2001	(6,839)						27
28	VWC	2002	1,172						28
29	Carpet	2002	1,534						29
30	Border	2002	111						30
31	Border	2002	125						31
32	Brick Work	2002	5,787						32
33	Addition Cost Brick Work	2002	643						33
34	TOTAL (lines 1 thru 33)		$ 3,333,631	$ 119,900		$ 119,900	$	$ 2,280,556	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,333,631	$ 119,900		$ 119,900	$	$ 2,280,556	1
2	Artwork	2002	2,219						2
3	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2002	(2,219)						3
4	Paint & Wallcovering	2002	2,810						4
5	Paint & Wallcovering	2002	3,122						5
6	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						6
7	Overhead & Interest	2003	431						7
8	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)						8
9	Paint, Flooring & VWC	2003	12,182						9
10	Paint, Flooring & VWC	2003	1,354						10
11	Freight on Carpet	2003	56						11
12	Carpet, Wallcovering and Corner Guards	2003	12,197						12
13	Developers Costs - Architect & Engineering Fees	2003	96,312						13
14	7/1/06 Capital Rate Adj #4	2003	(10,839)						14
15	7/1/06 Capital Rate Adj #5	2003	(17,967)						15
16	Developers Costs - T&E, Reprod.,Permit & Plan Review Fees	2003	15,798						16
17	7/1/06 Capital Rate Adj #6	2003	(5,436)						17
18	Developers Costs - Overhead	2003	152,775						18
19	7/1/06 Capital Rate Adj #7	2003	(152,775)						19
20	Developers Costs - Interest	2003	13,748						20
21	7/1/06 Capital Rate Adj #8	2003	(13,748)						21
22	Millwork	2003	4,664						22
23	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						23
24	7/1/06 Capital Rate Adj #2	2003	(6,851)						24
25	Site Work/Preparation	2003	74,492						25
26	7/1/06 Capital Rate Adj #3	2003	(74,492)						26
27	CONSULTING SERVICES-PHASE 2 ADDITION	2003	3,200						27
28	ARCHITECTURAL SERVICES	2003	9,117						28
29	ENGINEERING COST-CENTRAL BATH RENOV	2004	4,013						29
30	ENGINEERING COST-CENTRAL BATH RENOV	2004	6,479						30
31	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	723						31
32	ARCHITECTURAL COST-CENTRAL BATH RENOV	2004	180						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,506,529	$ 119,900		$ 119,900	$	$ 2,280,556	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,506,529	$ 119,900		$ 119,900	$	$ 2,280,556	1
2	ENGINEERING COST-CENTRAL BATH RENOV	2004	450						2
3	VINYL WALL COVERING	2004	266						3
4	BORDER	2004	948						4
5	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	2,986						5
6	BORDER FOR BATH	2004	85						6
7	ENGINEERING COST-CENTRAL BATH RENOV	2004	2,794						7
8	CARPET &COVE BASE	2004	6,273						8
9	VINYL WALL COVERING	2004	8,199						9
10	GAZEBO	2004	6,389						10
11	MATERIAL & SVCS-NURSING STA & BATH	2004	93,206						11
12	VINYL WALL COVERING	2005	497						12
13	GENERAL CONTRACTOR	2005	117,042						13
14	7/1/06 Capital Rate Adj #9	2005	(117,042)						14
15	SOIL TESTING	2005	1,790						15
16	7/1/06 Capital Rate Adj #10	2005	(1,790)						16
17	GAS SERVICE	2005	321						17
18	7/1/06 Capital Rate Adj #11	2005	(321)						18
19	SOIL TESTING	2005	3,370						19
20	7/1/06 Capital Rate Adj #12	2005	(3,370)						20
21	CONCRETE TESTING	2005	2,555						21
22	7/1/06 Capital Rate Adj #13	2005	(2,555)						22
23	GENERAL OVERHEAD	2005	8,273						23
24	7/1/06 Capital Rate Adj #15	2005	(8,273)						24
25	INTEREST ON CONSTRUCTION	2005	426						25
26	7/1/06 Capital Rate Adj #16	2005	(426)						26
27	CARPETING & PADS	2005	708						27
28	WALL COVERING	2005	4,135						28
29	CARPENTRY	2005	68,875						29
30	DRYWALL/STUDS	2005	1,500						30
31	DOORS/FRAMES	2005	1,125						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,704,964	$ 119,900		$ 119,900	$	$ 2,280,556	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,704,964	$ 119,900		$ 119,900	$	$ 2,280,556	1
2	ARCHITECT & ENGINEER COST	2005	59,040						2
3	ARCHITECT & ENGINEER COST	2005	8,988						3
4	ENGINEERING - CIVIL	2005	9,080						4
5	ENGINEERING - ELECTRIC	2005	600						5
6	LANDSCAPE DESIGN CONTRACTOR	2005	12,705						6
7	OVERHEAD	2005	106,428						7
8	7/1/06 Capital Rate Adj #18	2005	(106,428)						8
9	PERMIT FEES	2005	2,825						9
10	PLAN REVIEWS	2005	8,271						10
11	7/1/06 Capital Rate Adj #19	2005	(8,271)						11
12	INTEREST ON CONSTRUCTION	2005	16,467						12
13	7/1/06 Capital Rate Adj #20	2005	(16,467)						13
14	CARPETING AND PADS	2005	2,835						14
15	WALL COVERING	2005	9,095						15
16	CORNER GUARDS	2006	225						16
17	FIRE PROTECTION PIPING	2006	600						17
18	BASIC ELECTRICAL	2006	490						18
19	WALLCOVERINGS	2006	1,215						19
20	3 SETS OF DOORS	2006	4,226						20
21	INSTALL GUTTERS/WINDOWS	2006	14,500						21
22	VINYL WALL COVERING	2006	150						22
23	GUTTERS	2006	2,025						23
24	FLOORING-KITCHEN STORAGE	2006	6,278						24
25	EXPAND FREEZER & COOLER	2006	30,957						25
26	DOOR	2006	3,041						26
27	SIDEWALKS	2007	6,879						27
28	SIDEWALKS	2007	2106						28
29	boiler room door	2007	2419						29
30	Fire Sprinkler System	2007	2728						30
31	Architecture for Concrete	2007	1739						31
32	LAUNDRY RM IMP-DRYWALL, PAINT & DOORS	2007	11516						32
33	DOOR LEADING TO KITCHEN	2007	2127						33
34	TOTAL (lines 1 thru 33)		$ 3,903,353	$ 119,900		$ 119,900	$	$ 2,280,556	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,903,353	$ 119,900		$ 119,900	$	$ 2,280,556	1
2	0707 NURSE STATION GEN'L OH	2007	631						2
3	0707 NURSE STATION CARPENTRY	2007	16655						3
4	0707 NURSE STATION CABINETS	2007	12567						4
5	HOT WATER HEATER	2008	11677						5
6	new garage	2008	10325						6
7	PT DOUBLE DOORS	2008	4750						7
8	OT DOUBLE DOORS	2008	4750						8
9	NEW GARAGE	2008	10325						9
10	garage work	2008	1950						10
11	Door Replacement / Renovation	2008	2157						11
12									12
13	Concrete Ramp	2008	10,800						13
14	HVAC Controls	2009	2,540						14
15	HVAC Controls	2009	39,798						15
16									16
17	BI 040685 Kithen door	2010	2,470						17
18	BI 040686 front enterance awning	2010	3,198						18
19	BI 040688 adj asset 40686-frnt ent awning	2010	3,198						19
20	BI 040689 VCT flooring	2010	13,925						20
21	BI 040690 add'l cost VCT flooring	2010	13,925						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,068,994	$ 119,900		$ 119,900	$	$ 2,280,556	34

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,585,509	$ 83,096	$ 83,096	$		$ 1,340,465	71
72	Current Year Purchases	37,735						72
73	Fully Depreciated Assets							73
74	Home Office			7,167	7,167			74
75	TOTALS	$ 1,623,244	$ 83,096	$ 90,263	$ 7,167		$ 1,340,465	75

D. Vehicle Depreciation (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		$ 20,718	$	$	$		$ 20,718	76
77		chair lift								77
78										78
79										79
80	TOTALS			$ 20,718	$	$	$		$ 20,718	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)	$ 5,881,916	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 202,996	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,167	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,641,739	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] 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:	N/A			$			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 27,441 Description: 02 Concentrators, Wheelchairs, Gerichairs, Electric beds, etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transporation	Various	$	$ 7,885	17
18					18
19				above figure includes	19
20				gas & maintenance too	20
21	TOTAL		$	$ 7,885	21

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

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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Heartland of Galesburg STATE OF ILLINOIS # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	556	hrs	$ 20,947	541	$ 30,829	$ 223	1,097	$ 51,999	1
2	Licensed Speech and Language Development Therapist	10a	2659	hrs	100,262			49	2,659	100,311	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2855	hrs	107,631			2,676	2,855	110,307	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				205,744		205,744	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education	43, 2		hrs							11
12	Other (specify): IV Therapy							17,291		17,291	12
13	Other (specify): X-ray & lab	43, 3					25,352			25,352	13
14	TOTAL				$ 228,840	541	$ 56,181	$ 225,983	6,611	$ 511,004	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.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,775	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 84,014)	483,234		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)**	$ 499,009	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,960		13
14	Buildings, at Historical Cost	4,068,995		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,643,963		16
17	Accumulated Depreciation (book methods)	(3,641,739)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,240,179	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,739,188	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 66,590	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,826		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,586		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,726		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	42,703		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 389,431	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 389,432	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,349,756	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,739,188	$	48

*(See instructions.)

Facility Name & ID Number Heartland of Galesburg **#** 0049460 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,672,836	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,672,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	530,426	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)**	$ 530,426	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(853,506)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (853,506)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,349,756	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,988,478	1
2	Discounts and Allowances for all Levels	(1,675,169)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,313,309	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,203,332	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,203,332	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	616	12
13	Barber and Beauty Care	10,951	13
14	Non-Patient Meals	25,088	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	220,495	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	88,119	19
20	Radiology and X-Ray	49,809	20
21	Other Medical Services	59,079	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 454,157	23
	D. Non-Operating Revenue		
24	Contributions	750	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 750	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)**	$ 5,971,548	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	879,359	31
32	Health Care	2,398,534	32
33	General Administration	1,534,334	33
	B. Capital Expense		
34	Ownership	322,280	34
	C. Ancillary Expense		
35	Special Cost Centers	260,625	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,441,122	40
41	**Income before Income Taxes (line 30 minus line 40)****	530,426	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 530,426	43

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

****** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

******* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

******** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,954	2,135	$ 62,614	$ 29.33	1
2	Assistant Director of Nursing	5,398	5,897	152,389	25.84	2
3	Registered Nurses	8,489	9,274	219,520	23.67	3
4	Licensed Practical Nurses	19,952	21,797	380,051	17.44	4
5	CNAs & Orderlies	50,623	55,305	587,751	10.63	5
6	CNA Trainees					6
7	Licensed Therapist	6,070	6,620	249,570	37.70	7
8	Rehab/Therapy Aides	7,458	8,133	228,678	28.12	8
9	Activity Director	1,857	2,030	37,361	18.40	9
10	Activity Assistants					10
11	Social Service Workers	5,273	5,762	108,164	18.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,278	17,788	182,221	10.24	15
16	Dishwashers					16
17	Maintenance Workers	1,865	2,041	39,581	19.39	17
18	Housekeepers	10,894	11,908	122,211	10.26	18
19	Laundry	3,393	3,705	34,584	9.33	19
20	Administrator	2,080	2,080	76,564	36.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,552	11,469	225,168	19.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,026	2,215	26,685	12.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,162	168,159	$ 2,733,112 *	$ 16.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	21,180	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	(57)	10, 3	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)		$ 21,123		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lorna M. Brown	Administrator	0	$ 76,564
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,564

B. Administrative - Other

Description	Amount
Management Fees	$ 275,898
TOTAL (agree to Schedule V, line 17, col. 3)	$ 275,898
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Littler Mendelson PC	Legal Fees	$ 2,423
Michael T Mahoney, LTD	Legal Fees	2,372
United Collection Bureau	Collection Services	222
(All legal fees were 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.)		$ 5,017

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,257
Unemployment Compensation Insurance	32,546
FICA Taxes	190,234
Employee Health Insurance	230,708
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	13,067
Appreciation & Other Employee Benefits	6,129
Tuition Program	885
SMSP Match & RSU	17
Employee Uniforms	4,022
Home Office Allocation	20,673
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,538

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	$ 4,570
Advertising: Employee Recruitment	7,499
Health Care Worker Background Check	1,719
(Indicate # of checks performed 76)	
Patient Background Checks 250	2,500
Dues & Subscriptions	
Association Dues	7,845
Advertising (non-allowable)	23,349
Advertising (allowable)	11,919
Less non-allowable Association Dues	(4,707)
Less: Public Relations Expense	(11,919)
Non-allowable advertising	(23,349)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,426

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,695
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,695

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland of Galesburg # 0049460 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 $3138**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes $3496** 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. $ **48,312** 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? **No**
If YES, give effective date of lease.

(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. $ **45,990**
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. $ **25,088**

(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) 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.