

		FOR BHF USE					

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**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)**

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

<p><b>I. IDPH License ID Number:</b> <u>0049452</u></p> <p><b>Facility Name:</b> <u>Heartland of Henry IL, LLC</u></p> <p><b>Address:</b> <u>1650 Indian Town Road</u> <u>Henry</u> <u>61537</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Marshall</u></p> <p><b>Telephone Number:</b> <u>(309) 364-3905</u> <b>Fax #</b> <u>(309) 364-2247</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/10/1988</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Garv Geise</u> <b>Telephone Number:</b> <u>(419) 252-5731</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p><b>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</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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	<input type="checkbox"/> Other _____																												
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<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )																												

Facility Name & ID Number Heartland of Henry IL, LLC

# 0049452 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	6,431	13,274	7,486	27,191	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	6,431	13,274	7,486	27,191	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.25%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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

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 4/1/1989

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 66 and days of care provided 5,704

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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 Henry IL, LLC # 0049452 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

**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
	<b>A. General Services</b>										
1	Dietary	231,906	14,056	11,271	257,233	1,203	258,436		258,436		1
2	Food Purchase		172,324		172,324		172,324	(3,356)	168,968		2
3	Housekeeping	79,414	13,621	7,332	100,367		100,367		100,367		3
4	Laundry	53,416	13,040	186	66,642		66,642		66,642		4
5	Heat and Other Utilities			155,013	155,013		155,013		155,013		5
6	Maintenance	45,082	16,249	55,246	116,577		116,577		116,577		6
7	Other (specify):* <b>Medical Waste</b>			370	370		370		370		7
8	<b>TOTAL General Services</b>	<b>409,818</b>	<b>229,290</b>	<b>229,418</b>	<b>868,526</b>	<b>1,203</b>	<b>869,729</b>	<b>(3,356)</b>	<b>866,373</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,000	16,000		16,000		16,000		9
10	Nursing and Medical Records	1,609,387	116,568	88,709	1,814,664	7,593	1,822,257		1,822,257		10
10a	Therapy	510,508	5,832	30,889	547,229		547,229		547,229		10a
11	Activities	75,945	7,768	1,820	85,533		85,533	(75)	85,458		11
12	Social Services	79,526	3,837	1,054	84,417		84,417		84,417		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,275,366</b>	<b>134,005</b>	<b>138,472</b>	<b>2,547,843</b>	<b>7,593</b>	<b>2,555,436</b>	<b>(75)</b>	<b>2,555,361</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	87,963		255,785	343,748	(79,706)	264,042		264,042		17
18	Directors Fees										18
19	Professional Services			3,200	3,200		3,200	(558)	2,642		19
20	Dues, Fees, Subscriptions & Promotions			62,097	62,097		62,097	(47,862)	14,235		20
21	Clerical & General Office Expenses	167,382	41,867	112,230	321,479		321,479	(82,587)	238,892		21
22	Employee Benefits & Payroll Taxes			517,617	517,617	16,232	533,849		533,849		22
23	Inservice Training & Education			3,958	3,958		3,958		3,958		23
24	Travel and Seminar			21,283	21,283		21,283		21,283		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			259,726	259,726		259,726		259,726		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>255,345</b>	<b>41,867</b>	<b>1,235,896</b>	<b>1,533,108</b>	<b>(63,474)</b>	<b>1,469,634</b>	<b>(131,007)</b>	<b>1,338,627</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,940,529</b>	<b>405,162</b>	<b>1,603,786</b>	<b>4,949,477</b>	<b>(54,678)</b>	<b>4,894,799</b>	<b>(134,438)</b>	<b>4,760,361</b>		<b>29</b>

\*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 &amp; ID Number

Heartland of Henry IL, LLC

#0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			235,355	235,355	8,389	243,744		243,744			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			552,981	552,981	46,289	599,270	(554,840)	44,430			32
33	Real Estate Taxes			137,323	137,323		137,323		137,323			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,142	25,142		25,142		25,142			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			950,801	950,801	54,678	1,005,479	(554,840)	450,639			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,525	350	97,875		97,875		97,875			39
40	Barber and Beauty Shops			15,905	15,905		15,905		15,905			40
41	Coffee and Gift Shops	15,533			15,533		15,533		15,533			41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*		28,903	25,476	54,379		54,379		54,379			43
44	<b>TOTAL Special Cost Centers</b>	15,533	126,428	93,196	235,157		235,157		235,157			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,956,062	531,590	2,647,783	6,135,435		6,135,435	(689,278)	5,446,157			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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,356)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(416)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(11,294)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(558)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,748)	21		24
25	Fund Raising, Advertising and Promotional	(47,862)	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	(566,040)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (689,278)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (689,278)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Heartland of Henry II, LLC

ID# 0049452

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Wages - Marketing	\$ (4,912)	21	1
2	Employee benefits - Marketing	(1,339)	21	2
3	HCP Lease Interest	(554,840)	32	3
4	Vending Income	(4,874)	21	4
5	Misc. Income		21	5
6	Acitivity Income	(75)	11	6
7	Loss on Disposal of Fixed Assets		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	<b>Total</b>	(566,040)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## 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	(3,356)	0	0	0	0	0	0	0	0	0	0	(3,356)	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	<b>TOTAL General Services</b>	<b>(3,356)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,356)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(75)	0	0	0	0	0	0	0	0	0	0	(75)	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	<b>TOTAL Health Care and Programs</b>	<b>(75)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(75)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(558)	0	0	0	0	0	0	0	0	0	0	(558)	19
20	Fees, Subscriptions & Promotions	(47,862)	0	0	0	0	0	0	0	0	0	0	(47,862)	20
21	Clerical & General Office Expenses	(82,587)	0	0	0	0	0	0	0	0	0	0	(82,587)	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	<b>TOTAL General Administration</b>	<b>(131,007)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(131,007)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(134,438)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(134,438)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/2011 Ending:

Summary B

12/31/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	(554,840)	0	0	0	0	0	0	0	0	0	0	(554,840)	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	<b>TOTAL Ownership</b>	<b>(554,840)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(554,840)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(689,278)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(689,278)</b>	<b>45</b>



**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
		See PG6-Supp for list of related nursing homes in Illinois				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						
2	V	Page 8						
3	V							
4	V	1-44	Personnel	2,956,062	Heartland Employment Services, LLC	100.00%	2,956,062	
5	V							
6	V	10a	Therapy Management	11,197	Heartland Rehab Services, LLC	100.00%	11,197	
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 3,223,044			\$ 3,223,044	\$ *	14

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





Facility Name & ID Number Heartland of Henry IL, LLC # 0049452 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending: 2/31/2011

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	3,765,230,368	731 NFs, HHs, & Re	\$ 775,999	\$ 5,838,622	\$ 1,203	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs		5,838,622	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs		5,838,622	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs		5,838,622	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	485,056	352,684	5,838,622	752
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	5,838,622	6,841
7	10	Nursing - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs		5,838,622	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs		5,838,622	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	71,430,003	38,287,220	5,838,622	110,764
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	5,838,622	41,337
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	5,838,622	12,956
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	5,838,622	11,022
13	22	Employee Benefits - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	2,952,374		5,838,622	4,578
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		5,838,622	11,654
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			5,838,622	0
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			5,838,622	0
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	4,719,938		5,838,622	7,319
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		5,838,622	1,070
19	30	Depreciation - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			5,838,622	0
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			5,838,622	0
21	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		5,838,622	40,850
22	32	Directly Assigned Interest	Not Allocated			18,851,990			5,439
23		H/O Costs Allocated to Non-SNFs and Other Divisions				32,615,916			
24									
25	TOTALS					\$ 195,623,363	\$ 61,082,869	\$ 255,785	25

Facility Name & ID Number

Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Various		X	Facility				\$ 81,733	\$ 81,733		0.0665	\$ 5,439	1						
2													2						
3													3						
4													4						
5													5						
<b>Working Capital</b>																			
6													6						
7	Home Office Pooled Interest											40,850	7						
8	Interest Income Other											(1,859)	8						
9	<b>TOTAL Facility Related</b>						\$ 81,733	\$ 81,733				\$ 44,430	9						
<b>B. Non-Facility Related*</b>																			
10													10						
11													11						
12													12						
13													13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 81,733	\$ 81,733				\$ 44,430	15						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2010 report.		\$	<b>128,167</b>		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.)		\$	<b>132,745</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,578</b>		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>132,745</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>137,323</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<b>106,392</b>			8
	2007	<b>104,469</b>			9
	2008	<b>110,954</b>			10
	2009	<b>110,954</b>			11
	2010	<b>132,745</b>			12
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.**

**2010 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heartland of Henry IL, LLC COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0049452

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 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-09-326-001</u>	<u>See attached</u>	\$ <u>132,744.96</u>	\$ <u>132,744.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>132,744.96</u>	\$ <u>132,744.96</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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 Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,130 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 174,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 174,000</b>	<b>3</b>

Facility Name &amp; ID Number Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1988	1988	\$ 1,748,953	\$ 53,363		\$ 53,363	\$	\$ 1,109,682	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>CURRENT YEAR DEPRECIATION</b>					94,006		94,006		1,259,740	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	7/1/03 Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						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 &amp; ID Number Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,948,456	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	70

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/2011 Ending: 12/31/2011**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,948,456	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	1
2	<u>PAINING FOR RESIDENTS ROOMS</u>	2000	3,000						2
3	<u>DOOR HARDWARE</u>	2000	906						3
4	<u>PAINING</u>	2000	730						4
5	<u>PAINING</u>	2000	3,000						5
6	<u>DRYWALL</u>	2000	(3,000)						6
7	<u>SMOKE DAMPERS</u>	2000	7,280						7
8	<u>ADDL'T COST SMOKE DAMPERS</u>	2000	658						8
9	<u>TOTAL DOORS</u>	2000	73						9
10	<u>WALLCOVERING</u>	2000	610						10
11	<u>WALLCOVERING</u>	2000	170						11
12	<u>WALLCOVERING</u>	2000	709						12
13	<u>WALLCOVERING</u>	2000	519						13
14		2000	299						14
15	<u>CEILING</u>								15
16	<u>CUSTOM WORKSTATION</u>	2001	1,225						16
17	<u>PAINT &amp; WALLCOVERING</u>	2001	2,067						17
18	<u>WALLCOVERING - LOUNGE RENOVATION</u>	2001	1,760						18
19	<u>WINDOWS</u>	2001	557						19
20	<u>HOT WATER HEATERS</u>	2001	855						20
21	<u>DRAPES</u>	2001	7,900						21
22	<u>CARPET</u>	2001	2,980						22
23	<u>ADDTL COSTS FOR CARPET</u>	2001	29,586						23
24	<u>CARPET</u>	2001	2,260						24
25	<u>WALLCOVERING</u>	2001	500						25
26	<u>WALLCOVERING</u>	2001	516						26
27	<u>CARPENTRY - LOUNGE RENOVATION</u>	2001	90						27
28	<u>DRAPES, SHADES, BLINDS - LOUNGE RENOVATION</u>	2001	6,002						28
29	<u>CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION</u>	2001	1,109						29
30	<u>PAINING, WALLCOVERING - LOUNGE RENOVATION</u>	2001	10,360						30
31	<u>PLUMBING - LOUNGE RENOVATION</u>	2001	9,691						31
32	<u>CONCRETE</u>	2001	4,425						32
33		2001	2,248						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,047,541	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/2011 Ending: 12/31/2011**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,047,541	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,268,248	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,268,248	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,528,481	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	34

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

Facility Name &amp; ID Number Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,528,481	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						19
20	2 concrete sidewalks	2008	2,600						20
21	CARPENTRY	2008	500						21
22	0907 EMERGENCY LIGHTING	2008	6,357						22
23	0907 EMERGENCY LIGHTING	2008	38,409						23
24	0907 EMERGENCY LIGHTING	2008	6,454						24
25	0907 EMERGENCY LIGHTING	2008	4,450						25
26	AC CONDENSING UNIT	2008	4,287						26
27	ELECTRICAL FOR TVS	2008	10,260						27
28	SERVICE DOOR ENTRANCE1	2008	5,365						28
29	FIRE RATED SHUTTER	2008	4,806						29
30	DOOR FOR ENTRANCE	2008	5,365						30
31	entrance doors	2008	1,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,711,720	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,711,720	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	1
2	BI 022449 0309 FLOORING REPLACEMENT	2010	25203						2
3	LI 022448 back door concrete pad	2010	4246						3
4	LI 022459 5' wide sidewalk, therapy	2010	4038						4
5	LI 022460 Seal & strip pkg lot	2010	4978						5
6	BI 022463 Radiant Heat Panels	2011	7450						6
7	BI 022469 135 Sprinkler Heads	2011	10215						7
8	BI 022481 PT reno-prime/paint ceilings, vwc removal	2011	41370						8
9	BI 022482 0211 PARKING LOT	2011	83215.32						9
10	BI 022484 Wallcovering	2011	19674.6						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,912,110	\$ 147,369		\$ 147,369	\$	\$ 2,369,422	34

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



Facility Name & ID Number Heartland of Henry IL, LLC

# 0049452

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	\$ 1,660,098	\$ 87,986	\$ 87,986	\$		\$ 1,451,401	71
72	Current Year Purchases	38,090						72
73	Fully Depreciated Assets							73
74	Home Office			8,389	8,389			74
75	TOTALS	\$ 1,698,188	\$ 87,986	\$ 96,375	\$ 8,389		\$ 1,451,401	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)	\$ 5,784,298	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,355	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,744	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,389	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,820,823	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:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ _____			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: \_\_\_\_\_ \*

**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: \$ 16,004 Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Patient transportation</u>	<u>2006 Ford Van</u>	\$ _____	\$ <u>9,138</u>	17
18					18
19				<u>above figure includes</u>	19
20				<u>gas &amp; maintenance too</u>	20
21	<b>TOTAL</b>		\$ _____	\$ <u>9,138</u>	21

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. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

\* 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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	2233 hrs	\$ 80,224		\$	\$ 930	2,233	\$ 81,154	1
2	Licensed Speech and Language Development Therapist	10a	736 hrs	26,424			47	736	26,471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	3682 hrs	132,245			4,855	3,682	137,100	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				97,525		97,525	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____	43, 2					28,903		28,903	12
13	Other (specify): <u>Xray &amp; lab</u>	43, 3					25,476		25,476	13
14	<b>TOTAL</b>			\$ 238,893		\$ 25,476	\$ 132,260	6,651	\$ 396,629	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452Report Period Beginning: 01/01/2011Ending: 12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (4,419)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>139,974</u> )	690,808		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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 686,389	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	3,912,110		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,698,188		16
17	Accumulated Depreciation (book methods)	(3,820,823)		17
18	Deferred Charges	12,454,042		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): <u>Construction in progress</u>	5,316		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 14,422,833	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,109,222	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 68,932	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,622		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,745		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Payable</u>	27,347		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 448,646	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	12,121,510		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 12,121,510	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 12,570,156	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,539,066	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 15,109,222	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,916,580</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,916,580</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>878,830</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>878,830</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in interdivision</b>	<b>(256,344)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(256,344)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,539,066</b>	<b>24</b> *

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

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**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,885,222	1
2	Discounts and Allowances for all Levels	(1,441,919)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,443,303</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,330,022	6
7	Oxygen	72	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,330,094</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,878	12
13	Barber and Beauty Care	20,612	13
14	Non-Patient Meals	3,356	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,502	19
20	Radiology and X-Ray	2,720	20
21	Other Medical Services	31,498	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 229,574</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	11,294	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 11,294</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,014,265</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	868,526	31
32	Health Care	2,547,843	32
33	General Administration	1,533,108	33
<b>B. Capital Expense</b>			
34	Ownership	950,801	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	183,692	35
36	Provider Participation Fee	51,465	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,135,435</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>878,830</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 878,830</b>	<b>43</b>

\* 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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,184	\$ 77,034	\$ 35.27	1
2	Assistant Director of Nursing	3,461	3,794	94,500	24.91	2
3	Registered Nurses	15,400	16,883	387,040	22.92	3
4	Licensed Practical Nurses	15,091	16,545	326,637	19.74	4
5	CNAs & Orderlies	57,608	63,221	687,060	10.87	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	6,651	7,282	261,533	35.91	7
8	Rehab/Therapy Aides	8,299	9,086	248,975	27.40	8
9	Activity Director	6,132	6,728	75,945	11.29	9
10	Activity Assistants					10
11	Social Service Workers	3,746	4,111	79,526	19.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,309	22,284	231,906	10.41	15
16	Dishwashers					16
17	Maintenance Workers	2,351	2,575	45,082	17.51	17
18	Housekeepers	7,062	7,748	79,414	10.25	18
19	Laundry	5,131	5,629	53,416	9.49	19
20	Administrator	2,080	2,080	87,963	42.29	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,469	9,463	174,347	18.42	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	1,585	1,740	30,151	17.33	31
32	Other Health Care(specify)					32
33	Other(specify)	1,495	1,638	15,533	9.48	33
34	TOTAL (lines 1 - 33)	166,862	182,991	\$ 2,956,062 *	\$ 16.15	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	16,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	60,794	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)		\$ 76,794		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



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**XIX. SUPPORT SCHEDULES**

<b>A. Administrative Salaries</b>				<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>		
<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>	<b>Description</b>		<b>Amount</b>	<b>Description</b>		<b>Amount</b>
<a href="#">Susan Legner</a>	<a href="#">Administrator</a>	<a href="#">0</a>	<a href="#">\$ 87,963</a>	<a href="#">Workers' Compensation Insurance</a>		<a href="#">\$ 14,885</a>	<a href="#">IDPH License Fee</a>		<a href="#">\$ 2,241</a>
				<a href="#">Unemployment Compensation Insurance</a>		<a href="#">44,391</a>	<a href="#">Advertising: Employee Recruitment</a>		<a href="#">1,273</a>
				<a href="#">FICA Taxes</a>		<a href="#">209,508</a>	<a href="#">Health Care Worker Background Check (Indicate # of checks performed _____)</a>		
				<a href="#">Employee Health Insurance</a>		<a href="#">207,136</a>	<a href="#">Patient Background Checks</a>		<a href="#">4,533</a>
				<a href="#">Employee Meals</a>			<a href="#">Dues &amp; Subscriptions</a>		<a href="#">3,002</a>
				<a href="#">Illinois Municipal Retirement Fund (IMRF)* 401K</a>		<a href="#">30,971</a>	<a href="#">Association Dues</a>		<a href="#">11,072</a>
				<a href="#">Disability Payments</a>			<a href="#">Advertising (non-allowable)</a>		<a href="#">26,031</a>
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b> <b>(List each licensed administrator separately.)</b>			<b>\$ 87,963</b>	<a href="#">Other Employee Benefits &amp; Marketing Adj.</a>		<a href="#">5,520</a>	<a href="#">Advertising (allowable)</a>		<a href="#">13,945</a>
				<a href="#">Tuition Program</a>		<a href="#">2,500</a>	<a href="#">Less: non-allowable Association Dues</a>		<a href="#">(7,886)</a>
<b>B. Administrative - Other</b>				<a href="#">SMSP Match &amp; RSU</a>		<a href="#">53</a>	<a href="#">Less: Public Relations Expense</a>		<a href="#">(13,945)</a>
<b>Description</b>			<b>Amount</b>	<a href="#">Employee Uniforms</a>		<a href="#">2,653</a>	<a href="#">Non-allowable advertising</a>		<a href="#">(26,031)</a>
<a href="#">Home Office Costs</a>			<a href="#">\$ 255,785</a>	<a href="#">Home Office Allocation</a>		<a href="#">16,232</a>	<a href="#">Yellow page advertising</a>		<a href="#">( )</a>
							<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		<b>\$ 14,235</b>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b> <b>(Attach a copy of any management service agreement)</b>			<b>\$ 255,785</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>\$ 533,849</b>			
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
<b>Vendor/Payee</b>	<b>Type</b>		<b>Amount</b>	<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>Description</b>		<b>Amount</b>
<a href="#">United Collection Bureau Inc.</a>	<a href="#">Collection Services</a>		<a href="#">\$ 2,642</a>				<a href="#">Out-of-State Travel</a>		<a href="#">\$</a>
<a href="#">Michael T. Mahoney, LTD</a>	<a href="#">Legal Fees</a>		<a href="#">558</a>						
							<a href="#">In-State Travel</a>		<a href="#">21,283</a>
<a href="#">(All the above legal fees were adjusted off via Page 5, Line 22, therefore no invoices are attached.)</a>									
							<a href="#">Seminar Expense</a>		
							<a href="#">Entertainment Expense</a>		<a href="#">( )</a>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b> <b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>			<b>\$ 3,200</b>	<b>TOTAL</b>		<b>\$</b>	<b>TOTAL</b> <small>(agree to Sch. V, line 24, col. 8)</small>		<b>\$ 21,283</b>

\* Attach copy of IMRF notifications

\*\*See instructions.



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**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 \$3186
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$4503 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. \$ 39,463 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. \$ 51,465  
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. \$ 3,356
- (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?  
**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.