

		FOR BHF USE					

LL1

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.

I. IDPH License ID Number: <u>0049296</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heartland of Canton IL, LLC</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2081 North Main</u> <u>Canton</u> <u>61520</u>																									
Number City Zip Code																									
County: <u>Fulton</u>																									
Telephone Number: <u>(309) 647-6135</u> Fax # <u>(309) 647-6141</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Barry A. Lazarus</u></td></tr><tr><td>(Title) <u>Vice President, Reimbursement</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>	(Title) <u>Vice President, Reimbursement</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>																								
	(Title) <u>Vice President, Reimbursement</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>09/09/1988</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Garv Geise</u> Telephone Number: <u>(419) 252-5731</u>																									
Email Address: _____																									

Facility Name & ID Number Heartland of Canton IL, LLC

0049296 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	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,505</u>	<u>9,826</u>	<u>7,843</u>	<u>27,174</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,505</u>	<u>9,826</u>	<u>7,843</u>	<u>27,174</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.72%

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 09/26/1988

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 90 and days of care provided 4,041

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 Canton IL, LLC # 0049296 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	
	A. General Services											
1	Dietary	203,530	15,523	8,264	227,317		227,317		227,317			1
2	Food Purchase		188,021		188,021		188,021	(1,481)	186,540			2
3	Housekeeping	138,281	20,284	977	159,542		159,542		159,542			3
4	Laundry	9,641	10,404	537	20,582		20,582		20,582			4
5	Heat and Other Utilities			142,884	142,884	1,257	144,141		144,141			5
6	Maintenance	45,664	10,803	136,789	193,256		193,256		193,256			6
7	Other (specify):* Medical Waste			1,770	1,770		1,770		1,770			7
8	TOTAL General Services	397,116	245,035	291,221	933,372	1,257	934,629	(1,481)	933,148			8
	B. Health Care and Programs											
9	Medical Director			7,485	7,485		7,485		7,485			9
10	Nursing and Medical Records	1,773,405	156,446	61,474	1,991,325	7,932	1,999,257		1,999,257			10
10a	Therapy	528,265	3,302	11,864	543,431		543,431		543,431			10a
11	Activities	75,412	3,872	1,934	81,218		81,218		81,218			11
12	Social Services	85,463		3,020	88,483		88,483		88,483			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,462,545	163,620	85,777	2,711,942	7,932	2,719,874		2,719,874			16
	C. General Administration											
17	Administrative	81,011		266,925	347,936	(83,007)	264,929		264,929			17
18	Directors Fees											18
19	Professional Services			14,836	14,836		14,836	(14,813)	23			19
20	Dues, Fees, Subscriptions & Promotions			87,198	87,198		87,198	(60,626)	26,572			20
21	Clerical & General Office Expenses	243,448	38,521	103,886	385,855		385,855	(63,334)	322,521			21
22	Employee Benefits & Payroll Taxes			595,798	595,798	16,955	612,753		612,753			22
23	Inservice Training & Education			3,086	3,086		3,086		3,086			23
24	Travel and Seminar			21,163	21,163		21,163		21,163			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			247,913	247,913		247,913		247,913			26
27	Other (specify):*											27
28	TOTAL General Administration	324,459	38,521	1,340,805	1,703,785	(66,052)	1,637,733	(138,773)	1,498,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,184,120	447,176	1,717,803	5,349,099	(56,863)	5,292,236	(140,254)	5,151,982			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			333,861	333,861	8,760	342,621		342,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			311,681	311,681	48,103	359,784	(312,553)	47,231			32
33	Real Estate Taxes			74,541	74,541		74,541		74,541			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,975	40,975		40,975		40,975			35
36	Other (specify):*											36
37	TOTAL Ownership			761,058	761,058	56,863	817,921	(312,553)	505,368			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,821	2,821		2,821		2,821			38
39	Ancillary Service Centers		166,476		166,476		166,476		166,476			39
40	Barber and Beauty Shops			11,756	11,756		11,756		11,756			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*		6,599	41,356	47,955		47,955		47,955			43
44	TOTAL Special Cost Centers		173,075	105,208	278,283		278,283		278,283			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,184,120	620,251	2,584,069	6,388,440		6,388,440	(452,807)	5,935,633			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,481)	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	(337)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(565)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,813)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,980)	21		24
25	Fund Raising, Advertising and Promotional	(60,626)	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	(313,005)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (452,807)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (452,807)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0049296

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ 0	21	1
2	Employee benefits - Marketing	0	21	2
3	HCP Lease Interest	(312,553)	32	3
4	Vending Income	(452)	21	4
5	Misc. Income	0	21	5
6	Acitivity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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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	(313,005)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Canton IL, LLC # 0049296 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 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,481)	0	0	0	0	0	0	0	0	0	0	(1,481)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,481)	0	0	0	0	0	0	0	0	0	0	(1,481)	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	(14,813)	0	0	0	0	0	0	0	0	0	0	(14,813)	19
20	Fees, Subscriptions & Promotions	(60,626)	0	0	0	0	0	0	0	0	0	0	(60,626)	20
21	Clerical & General Office Expenses	(63,334)	0	0	0	0	0	0	0	0	0	0	(63,334)	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	(138,773)	0	0	0	0	0	0	0	0	0	0	(138,773)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(140,254)	0	0	0	0	0	0	0	0	0	0	(140,254)	29

Summary B

12/31/2011

Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
												(to Sch V, col.7)	
Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	(312,553)	0	0	0	0	0	0	0	0	0	0	(312,553)	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
TOTAL Ownership	(312,553)	0	0	0	0	0	0	0	0	0	0	(312,553)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(452,807)	0	0	0	0	0	0	0	0	0	0	(452,807)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care 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:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 266,925	HCR Manor Care Services, LLC	100.00%	\$ 266,925		1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,184,120	Heartland Employment Services, LLC	100.00%	3,184,120		4
5	V								5
6	V	10a	Therapy Management	10,720	Heartland Rehab Services, LLC	100.00%	10,720		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,461,765			\$ 3,461,765	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Champaign IL, LLC	Champaign				1
2			Heartland of Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland of Canton IL, LLC # 0049296 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 Canton IL, LLC # 0049296 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 ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	\$ 775,999	\$	6,098,518	\$ 1,257	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs			6,098,518	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			6,098,518	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			6,098,518	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	485,056	352,684	6,098,518	786	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	6,098,518	7,146	6
7	10	Nursing - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			6,098,518	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			6,098,518	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	71,430,003	38,287,220	6,098,518	115,695	9
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	6,098,518	43,177	10
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	6,098,518	13,533	11
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	6,098,518	11,513	12
13	22	Employee Benefits - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	2,952,374		6,098,518	4,782	13
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		6,098,518	12,173	14
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			6,098,518	0	15
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			6,098,518	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	4,719,938		6,098,518	7,645	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		6,098,518	1,115	18
19	30	Depreciation - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			6,098,518	0	19
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			6,098,518	0	20
21	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		6,098,518	42,668	21
22	32	Directly Assigned Interest	Not Allocated			18,851,990			5,435	22
23		H/O Costs Allocated to Non-SNFs and Other Divisions				32,615,916				23
24										24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 266,925	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Various		X	Facility			\$ 81,675	\$ 81,675		0.0665	\$ 5,435	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										42,668	7	
8	Interest Income Other										(872)	8	
9	TOTAL Facility Related						\$ 81,675	\$ 81,675			\$ 47,231	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 81,675	\$ 81,675			\$ 47,231	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	69,898	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.)				\$	72,220	2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,321	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	72,220	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	74,541	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	61,062	8	FOR BHF USE ONLY	
		2007	59,581	9		
		2008	66,134	10		
		2009	66,134	11		
		2010	72,220	12		
					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.

FACILITY NAME	<u>Heartland of Canton IL, LLC</u>	COUNTY	<u>Fulton</u>
---------------	------------------------------------	--------	---------------

CONTACT PERSON REGARDING THIS REPORT Gary Geise

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>

1.	09-08-15-205-007	See Attached	\$ 72,219.70	\$ 72,219.70
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 72,219.70	\$ 72,219.70

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?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

28,361

B. General Construction Type:

Exterior Brick

Frame Wood

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 55,973	1
2			2006 & 2008	2,153	2
3	TOTALS			\$ 58,126	3

Facility Name & ID Number Heartland of Canton IL, LLC

0049296

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	90		1988	1988	\$ 1,936,360	\$ 77,861		\$ 77,861	\$	1,595,921	4
5	Audit adj 7/1/03 (#1)			1988	(1,508)						5
6				1994	8,975						6
7				2006	364,683						7
8				2008	248,896						8
	Improvement Type**										
9	Land Improvements (Current Year Depreciation)					158,189		158,189		1,495,286	9
10	Site Work			1988	125,431						10
11	Sewer & Water Lines			1988	85,093						11
12	Paving			1988	82,940						12
13	Yew Trees			1991	4,440						13
14	Landscaping - Stone Wall			1992	3,812						14
15	Drain Tiles and Catch Basins			1992	7,550						15
16	AUDIT ADJ 7/1/03 (#2) - Drain Tiles			1992	(45)						16
17	AUDIT ADJ 7/1/03 (#2) -Reverse Adjustment			1992	45						17
18	Credit on Land Imp-CNCLD Retainer			1992	(755)						18
19	Fire Rated Door - Staff Development			1992	2,444						19
20	Plumbing - Mixing Valve			1992	676						20
21	Carpeting			1992	5,804						21
22	AUDIT ADJ 7/1/03 (#3) - Carpeting			1992	(5,804)						22
23	Carpet Vestibule Lounge - AUDIT ADJ 7/1/03 (#4) - CHG YEAR			1992	5,804						23
24	Renovation (Moved from CIP in 1995)			1993	5,360						24
25	Electrical (Moved from CIP in 1995)			1993	1,748						25
26	Aluminum Awning			1993	1,376						26
27	Wood Fence for Courtyard			1993	1,785						27
28	Replace Sod			1993	2,575						28
29	Seal & Stripe Parking Lot			1994	7,564						29
30	Painting			1994	994						30
31	Interior DR Remodel, Carpentry			1994	8,650						31
32	Elec, Plumb, DR Remodel			1994	5,130						32
33	Sprinkler Sys			1994	1,193						33
34	Carpet Lobby, Offices, Nurses Station			1994	13,908						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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 Concrete Sidewalk	1995	\$ 4,440	\$		\$	\$	\$	37
38 Fencing	1995	1,732						38
39 Vinyl Flooring	1995	949						39
40 Electrical	1995	1,154						40
41 Cabinets in Alzheimers Unit	1995	1,394						41
42 Counter Top	1995	244						42
43 Doors	1995	7,346						43
44 Architectural Fees A/L Lounge Renovation	1995	2,231						44
45 Electrical Engineering and Architectural Service Fees-CHG YR	1995	9,766						45
46 Carpet	1996	181						46
47 Painting	1996	1,750						47
48 Painting	1996	1,806						48
49 Labor, Material, Permits to Renovate A/L Lounge	1996	5,615						49
50 Carpeting	1996	1,060						50
51 (51) Doors	1996	8,278						51
52 Grilles for Sliding Glass Door for A/L Lounge	1996	181						52
53 Credit on BLD IMP- CNCLD Retainer	1996	(18)						53
54 Ceramic Tile	1996	3,511						54
55 Painting	1997	148						55
56 Architectural Services	1997	375						56
57 Architectural Services -Alzheimers Unit	1997	2,075						57
58 Additional Architectural Services	1997	500						58
59 Architectural Services - Alzheimers Unit	1997	575						59
60 Add'l HVAC Cost	1997	232						60
61 Architectural Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	3,725						61
62 Engineering Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	250						62
63 Construction Overhead and Interest-AUDIT ADJ 7/1/03 (#7) CHG	1997	18,034						63
64 HVAC - AUDIT AJD 7/1/03 (#7) CHG YEAR	1997	194,747						64
65 Lift Station - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	25,000						65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,222,406	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	70

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,222,406	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 HVAC	1998	35,458						2
3 A/C DESIGN & INSTALLATION	1998	36,185						3
4 AA ON ROOFTOP UNIT	1998	7,360						4
5 ROOF TOP UNIT	1998	11,100						5
6 FACIA BOARD & GUTTERS	1998	13,000						6
7 Asphalt Paving	1998	17,441						7
8 INSTALL HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,475						8
9 INSTALL DAMPER HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	643						9
10 INSTALL RTU HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,200						10
11 WALLCOVERINGS	1999	5,319						11
12 CONSTRUCTION OVERHEAD	1999	11,221						12
13 AUDIT ADJ 7/1/03 (#8) - OVERHEAD	1999	(11,221)						13
14 WALLCOVERINGS	1999	4,097						14
15 AUDIT ADJ 7/1/03 (#9) - WALLCOVERINGS	1999	(225)						15
16 SECURE CARE LOCKING SYSTEM	1999	5,101						16
17 PARTITIONS	1999	738						17
18 WALLCOVERINGS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,233						18
19 CORNER GUARDS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	251						19
20 COVE BASE-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	539						20
21 LOREN COOK ROOF EXHAUST-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,325						21
22 WALL VINYL COVERING	1999	1,936						22
23 CABINETS & TOPS	1999	5,247						23
24 PAINTING	1999	1,450						24
25 PAINTING	1999	17,000						25
26 AUDIT ADJ 7/1/03 (#11) - PAINTING	1999	(17,000)						26
27 FLOORING - COVE BASE	1999	1,258						27
28 CUSTOM CABINETS	1999	5,820						28
29 PAINTING	1999	15,000						29
30 CEILING INSTALLATION-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1999	10,367						30
31 AUDIT ADJ 7/1/03 (#13) - CEILING INSULATION	1999	(10,367)						31
32 DESIGN FEES FOR ALZHEIMERS UNIT	1999	1,050						32
33 DESIGN FEES FOR ALZHEIMERS UNIT	1999	(1,050)						33
34 TOTAL (lines 1 thru 33)		\$ 3,395,358	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,395,358	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 WALLCOVERING	1999	132						2
3 WALLCOVERING	1999	116						3
4 WALLCOVERING	1999	496						4
5 COOLER	1999	1,245						5
6 AUDIT ADJ 7/1/03 (#14) - COOLER	1999	(1,245)						6
7 WALLCOVERING	1999	744						7
8 AUDIT ADJ 7/1/03 (#15) - WALLCOVERING	1999	(744)						8
9 PAINTING	1999	33,450						9
10 AUDIT ADJ 7/1/03 (#16) - PAINTING	1999	(33,450)						10
11 CABINETRY & COUNTERTOPS	1999	11,067						11
12 AUDIT ADJ 7/1/03 (#17) - CABINETRY	1999	(11,067)						12
13 CARPETING & FLOORING	1999	1,258						13
14 AUDIT ADJ 7/1/03 (#18) - CARPETING	1999	(1,258)						14
15 HVAC	1999	3,318						15
16 AUDIT ADJ 7/1/03 (#19) - HVAC	1999	(3,318)						16
17 CEILING INSTALLATION	1999	10,367						17
18 AUDIT ADJ 7/1/03 (#20) - CEILING INSTALLATION	1999	(10,367)						18
19								19
20 FLOORING	2000	24,374						20
21 CONSTRUCTION OVERHEAD AND INTEREST	2000	31,653						21
22 AUDIT ADJ 7/1/03 (#21) - CONSTRUCTION	2000	(31,653)						22
23 DOOR HOLDERS	2000	1,623						23
24 FLOOR COVERING	2000	1,495						24
25 DRY SPRINKLER SYSTEM	2000	1,381						25
26 DRYWALL	2000	6,160						26
27 FREIGHT ON FABRIC	2001	534						27
28 FURNISH & INSTALL HANDRAILS	2001	943						28
29 DOORS	2001	4,200						29
30 ROOF	2001	13,000						30
31 COVE BASE	2001	5,885						31
32 AUDIT ADJ 7/1/03 (# 26) - COVE BASE	2001	(5,885)						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,449,813	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 3,449,813	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 RESIDENT ROOM PAINTING	2002	4,484						2
3 AUDIT ADJ 7/1/03 (# 27) - RESIDENT ROOM PAINTING	2002	(4,484)						3
4 RESIDENT ROOM PAINTING	2002	38,492						4
5 AUDIT ADJ 7/1/03 (#22) - PAINTING	2002	(2,814)						5
6 DOORS	2002	3,225						6
7 GENERAL CONSTRUCTION	2002	9,542						7
8 RENOVATION ELECTRICAL-AUDIT ADJ 7/1/03 (#24) CHG Y	2002	61,600						8
9 AUDIT ADJ 7/1/03 (#23) - RENOVATION ELECTRICAL	2002	(2,284)						9
10 STAINLESS STEEL VWC	2002	9,059						10
11 STAINLESS STEEL VWC	2002	1,007						11
12 ROOF	2003	17,781						12
13 ROOF	2003	970						13
14 7/1/06 CAPITAL RATE ADJUST #1	2003	(970)						14
15 ROOFING & SHEET METAL	2003	53,562						15
16 GENERAL CONSTRUCTION	2003	3,994						16
17 AUDIT ADJ 7/1/03 (#25) - GENERAL CONSTRUCTION	2003	(3,994)						17
18 CARPET AND INSTALL	2003	22,469						18
19 PAVING	2003	72,546						19
20 OVERHEAD & INTEREST	2003	8,586						20
21 AUDIT ADJ 12/03 (#1) OVERHEAD & INT	2003	(8,586)						21
22 AUDIT ADJ 7/1/03 (#5) - PG 12A LINE 47 + PG 12A LINE 55	2003	(2)						22
23 AUDIT ADJ 7/1/03 (#5) - REVERSAL	2003	2						23
24 CEILING	2004	1,817						24
25 WINDOW	2004	3,078						25
26 DOOR	2004	1,600						26
27 SHEET VINYL FLOORING	2004	7,250						27
28 CUSTOM CABINETS	2004	2,354						28
29 VCT AND COVE BASE	2004	2,250						29
30 ARCH & ENGINEERING COSTS	2005	2,420						30
31 ARCH & ENGINEERING COSTS	2005	423						31
32 HANDRAIL AND BACKER	2005	27,820						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,783,011	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	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	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		\$ 3,783,011	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 MAGNETIC DOOR	2005	2,515						2
3 METAL DOORS	2005	2,485						3
4 DOOR FRAMES	2005	24,900						4
5 ARCHITECT & ENGINEERING COSTS	2005	10,281						5
6 OVERHEAD & INTEREST	2005	10,238						6
7 7/1/06 CAPITAL RATE ADJUST #2	2005	(10,238)						7
8 INTEREST ON CONSTRUCTION	2005	735						8
9 7/1/06 CAPITAL RATE ADJUST #3	2005	(735)						9
10 WALLCOVERING	2005	1,452						10
11 7/1/06 CAPITAL RATE ADJUST #4	2005	(1,452)						11
12 PLAN REVIEWS	2005	2,400						12
13 BASIC ELECTRICAL	2005	71,574						13
14 INSTALLATION OF 10 PTAC UNITS	2005	616						14
15 GENERATOR	2006	7,415						15
16 GENERATOR	2006	5,493						16
17 INSTALLATION OF 5 PTAC UNITS	2006	3,275						17
18 ARCHITECT & ENGINEERING COSTS	2006	36,887						18
19 ARCHITECT & ENGINEERING COSTS	2006	6,472						19
20 ENGINEERING - CIVIL	2006	8,600						20
21 GENERAL OVERHEAD	2006	20,273						21
22 PLAN REVIEWS	2006	7,286						22
23 INTEREST ON CONSTRUCTION	2006	3,433						23
24 CARPETING & PADS	2006	1,615						24
25 WALLCOVERING	2006	1,845						25
26 SPRINKLERS	2006	1,075						26
27 HVAC	2006	3,417						27
28 VINYL WALL COVERING	2006	1,022						28
29 VINYL WALL COVERING	2006	130						29
30 CARPET	2006	1,085						30
31 CARPENTRY	2006	15,800						31
32 GENERAL CONTRACTOR - PT ADDITION	2006	98,220						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,121,122	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 4,121,122	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 SOIL TESTING	2006	4,866						2
3 CONCRETE TESTING	2006	188						3
4 CONCRETE PAD AND RAMP	2007	13,712						4
5 1006 NURSE CALL SYSTEM	2007	8,691						5
6 1006 NURSE CALL SYSTEM	2007	1,133						6
7 window glass	2007	1,089						7
8 RETAINAGE FOR WIRING	2007	1,164						8
9 WIRING	2007	10,476						9
10 FIRE ALARM MOTHERBOARD	2007	1,620						10
11 CARPENTRY	2007	23,900						11
12 SIDEWALK	2007	23,500						12
13 SIDEWALK	2007	3,750						13
14 SIDEWALK INSTALLATION	2008	3,980						14
15 SIDEWALK	2008	1,070						15
16 ENG COSTS FOR SIDEWALK DESIGN	2007	5,447						16
17 CARPET - PT ADDITION	2008	3,337						17
18 CANTON PT ADT'N-GEN'L CNTR SITE WORK	2008	9,654						18
19 CANTON PT ADT'N-ARCH & ENGR COSTS	2008	55,263						19
20 CANTON PT ADT'N-GEN'L O-H CAPITAL	2008	83,955						20
21 CANTON PT ADT'N-PLAN REVIEWS	2008	6,000						21
22 CANTON PT ADT'N-INT ON COSTS	2008	12,978						22
23 CANTON PT ADT'N-MILLWORK	2008	131						23
24 CANTON PT ADT'N-RESILIENT FLOORING	2008	2,940						24
25 CANTON PT ADT'N-CARPETING & PADS	2008	3,347						25
26 CANTON PT ADT'N-WALL COVERING	2008	4,099						26
27 CANTON PT ADT'N-CORNER GUARDS	2008	195						27
28 DOOR OPENERS	2008	6,085						28
29 garage electrical	2008	318						29
30 garage electrical	2008	2,862						30
31 SPRINKLER PIPING	2008	20,000						31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,436,871	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 4,436,871	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	1
2 Parking Blocks	2009	7,200						2
3 FIRE ALARM MOTHERBOARD	2007	(1,620)						3
4 paint 32 rooms	2008	3,350						4
5 adj asset 20422	2007	(1,620)						5
6 sprinkler system	2009	25,430						6
7 sprinkler system	2009	151						7
8 drainage piping	2009	76,290						8
9 LI 020496 courtyard lights	2010	3,225						9
10 LI 020497 sidewalk	2010	7,445						10
11 LI 020498 add'l cost sidewalk	2010	7,445						11
12								12
13 BI 020502 double egress doors	2010	13,510						13
14 BI 020509 Install radiant heat in halls, dining room, lobby,	2011	35,202						14
15 BI 020510 install radiant heat in halls, dining room, lobby,	2011	3,612						15
16 BI 020522 remove walls, patch, paint, primer walls	2011	36,927						16
17 BI 020524 WATER HEATER	2010	9,250						17
18 BI 020529 CABINTRY FOR CHARTING	2011	2,982						18
19 BI 020532 remove walls, patch, paint, primer walls	2011	3,285						19
20 BI 020533 double egress doors	2011	3,104						20
21 BI 020535 ADJUST ASSET # 20509	2011	2,950						21
22 BI 020537 WATER HEATER	2011	5,604						22
23 LI 020501 concrete sidewalk	2010	4,325						23
24 LI 020506 sealcoat pkg lot	2010	9,797						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)		\$ 4,694,714	\$ 236,050		\$ 236,050	\$	\$ 3,091,207	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,579,955	\$97,811	\$97,811	\$		\$1,345,001	71
72	Current Year Purchases	127,530						72
73	Fully Depreciated Assets							73
74	Home Office			8,760	8,760			74
75	TOTALS	\$1,707,485	\$97,811	\$106,571	\$8,760		\$1,345,001	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)	\$6,460,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$333,861	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$342,621	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,760	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,436,208	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: N/A
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:	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:
- *

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

15. Is Movable equipment rental included in building rental?
☐ YES☐ NO
16. Rental Amount for movable equipment: \$18,084
- Description: O2 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 Transportation	2006 Ford E350 Van	\$varies	\$22,891	17
18					18
19					19
20					20
21	TOTAL		\$	22,891	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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	1980	hrs	\$ 79,703		\$ 280	1,980	\$ 79,983	1
2	Licensed Speech and Language Development Therapist	10a	2129	hrs	85,708		464	2,129	86,172	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a	3107	hrs	125,063		2,558	3,107	127,621	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			166,476		166,476	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): IV therapy	43, 2					6,599		6,599	12
13	Other (specify): Xray & lab	43, 3				41,356			41,356	13
14	TOTAL				\$ 290,474	\$ 41,356	\$ 176,377	7,216	\$ 508,207	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,533	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 145,654)	812,246		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)	\$ 834,779	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,126		13
14	Buildings, at Historical Cost	4,694,712		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,707,486		16
17	Accumulated Depreciation (book methods)	(4,436,208)		17
18	Deferred Charges	899,824		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)	\$ 2,923,940	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,758,719	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,949	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,104		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,220		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	19,839		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 377,112	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,019,223		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,019,223	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,396,335	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,637,616)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,758,719	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,254,267	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,254,267	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(205,992)	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)	\$ (205,992)	17
	B. Transfers (Itemize):		
18	Change in interdivision	(3,685,891)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,685,891)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,637,616)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,137,205	1
2	Discounts and Allowances for all Levels	(1,180,107)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,957,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	953,488	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 953,488	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	452	12
13	Barber and Beauty Care	14,845	13
14	Non-Patient Meals	1,481	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	163,982	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,672	19
20	Radiology and X-Ray	13,007	20
21	Other Medical Services	31,858	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 271,297	23
	D. Non-Operating Revenue		
24	Contributions	565	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 565	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)	\$ 6,182,448	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	933,372	31
32	Health Care	2,711,942	32
33	General Administration	1,703,785	33
	B. Capital Expense		
34	Ownership	761,058	34
	C. Ancillary Expense		
35	Special Cost Centers	229,008	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,388,440	40
41	Income before Income Taxes (line 30 minus line 40)**	(205,992)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (205,992)	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.

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	1,967	2,153	\$ 66,740	\$ 31.00	1
2	Assistant Director of Nursing	3,726	4,078	109,669	26.89	2
3	Registered Nurses	12,636	13,829	348,437	25.20	3
4	Licensed Practical Nurses	22,730	24,877	524,606	21.09	4
5	CNAs & Orderlies	56,486	61,821	689,145	11.15	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	7,217	7,893	317,658	40.25	7
8	Rehab/Therapy Aides	6,349	6,943	210,607	30.33	8
9	Activity Director	5,757	6,304	75,412	11.96	9
10	Activity Assistants					10
11	Social Service Workers	3,856	4,219	85,463	20.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,237	19,950	203,530	10.20	15
16	Dishwashers					16
17	Maintenance Workers	1,815	1,984	45,664	23.02	17
18	Housekeepers	12,545	13,728	138,281	10.07	18
19	Laundry	1,025	1,117	9,641	8.63	19
20	Administrator	2,080	2,080	81,011	38.95	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,360	13,655	250,411	18.34	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	1,870	2,052	27,845	13.57	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	170,656	186,683	\$ 3,184,120 *	\$ 17.06	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	7,485	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,485		49

C. CONTRACT NURSES

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

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

** See instructions.

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 \$3051

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes \$4081

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.

\$ 47,402

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.

\$ 49,275

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 1,481

(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 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.