

		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: 0049395

Facility Name: Heartland of Champaign IL, LLC

Address: 309 East Springfield Champaign 61820
Number City Zip Code

County: Champaign

Telephone Number: (217) 352-5135 Fax # (217) 352-9139

HFS ID Number:

Date of Initial License for Current Owners: 11/1/81

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/10 to 05/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heartland of Champaign IL, LLC

0049395 Report Period Beginning: 06/01/10 Ending: 05/31/11

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>102</u>	Skilled (SNF)	<u>102</u>	<u>37,230</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>102</u>	TOTALS	<u>102</u>	<u>37,230</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>4,008</u>	<u>12,430</u>	<u>14,480</u>	<u>30,918</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>4,008</u>	<u>12,430</u>	<u>14,480</u>	<u>30,918</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.05%

D. How many bed-hold days during this year were paid by the Department? 11 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/07/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 102 and days of care provided 10,307

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Heartland of Champaign IL, LLC # 0049395 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	255,434	21,442	80,101	356,977	7,891	364,868		364,868			1
2	Food Purchase		273,704		273,704		273,704	(9,830)	263,874			2
3	Housekeeping	116,781	15,790	1,834	134,405		134,405		134,405			3
4	Laundry	55,571	27,370	10,389	93,330		93,330		93,330			4
5	Heat and Other Utilities			138,720	138,720	2,127	140,847		140,847			5
6	Maintenance	88,639	32,670	194,079	315,388		315,388		315,388			6
7	Other (specify):* Med Waste			777	777		777		777			7
8	TOTAL General Services	516,425	370,976	425,900	1,313,301	10,018	1,323,319	(9,830)	1,313,489			8
	B. Health Care and Programs											
9	Medical Director			47,563	47,563		47,563		47,563			9
10	Nursing and Medical Records	2,429,195	268,414	297,530	2,995,139	9,361	3,004,500		3,004,500			10
10a	Therapy	926,766	13,605	109,179	1,049,550		1,049,550		1,049,550			10a
11	Activities	79,280	11,081	7,355	97,716		97,716		97,716			11
12	Social Services	146,045	2,183	2,581	150,809		150,809		150,809			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,581,286	295,283	464,208	4,340,777	9,361	4,350,138		4,350,138			16
	C. General Administration											
17	Administrative	51,087		440,467	491,554	(103,859)	387,695		387,695			17
18	Directors Fees											18
19	Professional Services			6,460	6,460	(705)	5,755	(5,755)				19
20	Dues, Fees, Subscriptions & Promotions			78,480	78,480		78,480	(56,115)	22,365			20
21	Clerical & General Office Expenses	307,203	57,376	326,362	690,941	705	691,646	(116,651)	574,995			21
22	Employee Benefits & Payroll Taxes			923,221	923,221	35,950	959,171		959,171			22
23	Inservice Training & Education			3,008	3,008		3,008		3,008			23
24	Travel and Seminar			10,249	10,249		10,249		10,249			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			295,081	295,081		295,081		295,081			26
27	Other (specify):*											27
28	TOTAL General Administration	358,290	57,376	2,083,328	2,498,994	(67,909)	2,431,085	(178,521)	2,252,564			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,456,001	723,635	2,973,436	8,153,072	(48,530)	8,104,542	(188,351)	7,916,191			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			282,133	282,133	12,464	294,597		294,597			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,406	125,406	36,066	161,472	(128,017)	33,455			32
33	Real Estate Taxes			57,182	57,182		57,182		57,182			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,339	97,339		97,339		97,339			35
36	Other (specify):*											36
37	TOTAL Ownership			562,060	562,060	48,530	610,590	(128,017)	482,573			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			13,809	13,809		13,809		13,809			38
39	Ancillary Service Centers		382,979	1,990	384,969		384,969		384,969			39
40	Barber and Beauty Shops			12,357	12,357		12,357		12,357			40
41	Coffee and Gift Shops	52,677			52,677		52,677		52,677			41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):* IV Ther/Xray/Lab		61,373	115,560	176,933		176,933		176,933			43
44	TOTAL Special Cost Centers	52,677	444,352	199,561	696,590		696,590		696,590			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,508,678	1,167,987	3,735,057	9,411,722		9,411,722	(316,368)	9,095,354			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	(9,830)	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	(545)	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	(11,700)	21		18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,755)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,618)	21		24
25	Fund Raising, Advertising and Promotional	(56,115)	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 5a	(164,805)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (316,368)		\$	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))	\$ (316,368)		37

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

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

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

Report Period Beginning:

ID#0049395

Ending:

06/01/10

05/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing 600000707	\$ (27,038)	21	1
2	P/R O/H Alloc - Mktg 609000707	(9,025)	21	2
3	HCP Lease Interest 997060735	(128,017)	32	3
4	Vending Income 595010591	(725)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(164,805)		49

Summary A

05/31/11

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

[illegible]

Summary B

05/31/11

[illegible]

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	\$ 440,467	HCR Manor Care Services, LLC	100.00%	\$ 440,467		1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,508,678	Heartland Employment Services, LLC	100.00%	4,508,678		4
5	V	10a	Therapy Management	6,929	Heartland Rehabilitation Services, LLC	100.00%	6,929		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 4,956,074			\$ 4,956,074	\$ *	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 Canton IL, LLC	Canton				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 (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

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

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 Champaign IL, LLC # 0049395 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	1	Dietary - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	\$ 2,652,139	\$ 1,448,591	8,680,217	\$ 7,891	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			8,680,217	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab			8,680,217	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs			8,680,217	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			8,680,217	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab	817,551		8,680,217	2,127	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	8,680,217	8,033	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			8,680,217	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab	510,057	376,446	8,680,217	1,328	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	8,680,217	73,615	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	8,680,217	23,448	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab	92,052,254	34,999,867	8,680,217	239,545	12
13	22	Empl Bnfts - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309		8,680,217	21,692	13
14	22	Empl Bnfts - Direct to Cendtral Div	Accumulated Cost	692,663,974	92 NFs			8,680,217	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab	5,479,146		8,680,217	14,258	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954		8,680,217	851	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			8,680,217	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 Nfs,HHs, Rehab	4,462,801		8,680,217	11,613	18
19										19
20	32	Directly Assigned Interest				12,736,052			36,066	20
21		Non Central Div Nrsg Home Allocations				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 440,467	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv Sub Debentures		X	Various			\$ 802,268	\$ 802,268		0.0450	\$ 36,066	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income / Expense										(2,611)	8	
9	TOTAL Facility Related						\$ 802,268	\$ 802,268			\$ 33,455	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 802,268	\$ 802,268			\$ 33,455	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	60,769	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.)		\$	61,290	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	521	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	56,661	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.		\$	57,182	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	50,018	8	
		2007	52,976	9	
		2008	60,570	10	
		2009	60,769	11	
		2010	61,811	12	
Line 2: \$61,290.34 = \$30,384.69 for 2nd half of 2009 + \$30,905.65 for 1st half 2010				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
Line 4: \$56,661.00 = \$30,905.65 2nd half 2010 + \$25,755 for Jan - May 2011				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 Heartland of Champaign IL, LLC COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0049395

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

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.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

23,745

B. General Construction Type:

ExteriorMasonry

FrameSteel

Number of Stories

3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1968	\$54,050	1
2			2007	249,936	2
3	TOTALS			\$303,986	3

Facility Name & ID Number Heartland of Champaign IL, LLC

0049395

Report Period Beginning:

06/01/10

Ending:

05/31/11

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	102			1968	\$ 1,201,229	\$ (11,217)		\$ (11,217)	\$	1,311,395	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					180,627		180,627		2,219,732	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1987	(55,068)						13
14				1988	41,139						14
15				1989	1,297						15
16				1990	20,319						16
17				1991	50,575						17
18				1992	374,174						18
19	RETIREMENTS			1992	(6,784)						19
20				1993	51,354						20
21				1994	48,400						21
22				1995	229,982						22
23	ELECTRICAL WORK			1996	17,102						23
24	WALL VINYL			1996	10,548						24
25	VINYL FLOORING			1996	14,858						25
26	INSTALL CAMERA SYSTEM			1996	1,453						26
27	REMODEL 13 ROOMS AND LOBBY			1996	35,665						27
28	HVAC			1996	21,101						28
29	ROOF WORK			1996	1,365						29
30	CORPORATE OVERHEAD-13 ROOMS/LOBBY			1996	7,272						30
31	CONCRETE WORK			1996	3,880						31
32	CARPET			1996	5,900						32
33	DIGITAL KEYPAD			1996	1,915						33
34	INSTALL EMERGENCY GENERATOR			1996	44,791						34
35	INSTALL CIRCUIT BREAKER			1996	3,289						35
36	HVAC			1996	1,867						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	
37INSTALL COVE BASE/SIGNS	1996	\$2,612	\$		\$	\$	\$	37
38C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)						38
39WALLCOVERINGS	1997	12,165						39
40CARPET	1997	1,639						40
41INSTALL HYDROLIC CYLINDER	1997	14,249						41
42UNIT PROTECTION SWITCH	1997	6,354						42
43FURNISH/INSTALL TILES	1997	16,476						43
44HANDRAILS	1997	5,661						44
45PLUMBING	1997	7,610						45
46VINYL TILE	1997	1,643						46
47HAND RAILS	1997	1,450						47
48FACILITY PLAN ALLOC	1997	2,759						48
49INSTALL GATES	1997	1,226						49
50CORNER GUARDS	1997	314						50
51C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)						51
52ELECTRICAL	1998	2,598						52
53REPLACE WINDOWS	1998	2,763						53
54INSTALL QUARRY TILE	1998	1,640						54
55INSTALL DUCTWORK	1998	2,350						55
56CORPORATE OVERHEAD	1998	1,702						56
57SECURITY SYSTEM	1998	33,542						57
58ENTRYWAY/PARKING LOT WORK	1998	2,209						58
59ELEVATOR EQUIP EVAL	1998	700						59
60CARPENTRY	1998	355						60
61WALLPAPER	1998	400						61
62CARPETING/FLOORING	1998	2,471						62
63PLUMBING	1998	9,690						63
64ELECTRICAL	1998	1,367						64
65HVAC	1998	565						65
66PAINTING/WALLCOVERING	1998	10,552						66
67GENERAL REQ	1998	1,500						67
68CONTRACTORS	1998	2,507						68
69ROOFING	1998	500						69
70TOTAL (lines 4 thru 69)		\$2,355,636	\$169,410		\$169,410	\$	\$3,531,127	70

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

Facility Name & ID Number Heartland of Champaign IL, LLC

0049395

Report Period Beginning:

06/01/10

Ending:

05/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,355,636	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)						2
3	DOOR/WINDOW	1998	2,456						3
4	ELEVATORS	1998	3,433						4
5	SIGNAGE	1998	11,862						5
6	CARPETING	1999	5,993						6
7	CALL LIGHT SYSTEM	1999	42,342						7
8	1997 BILLING FOR CONSTRUCTION	1999	20,476						8
9	INSTALL SECURE DOOR KIT	1999	3,753						9
10	FABRIC FOR PATIENT FURNITURE	1999	121						10
11	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(121)						11
12	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						12
13	FABRIC FOR PATIENT FURNITURE	1999	674						13
14	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(674)						14
15	PAINT, WALLPAPER, CORRIDOR	1999	8,471						15
16	FIRE-SMOKE DAMPERS	1999	(581)						16
17	REMODEL KITCHEN RECEPTACLES	1999	4,800						17
18	NEW SHOWER BASE	1999	6,870						18
19	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						19
20	CERAMIC TILE - 2 SHOWERS	1999	2,718						20
21	FIRE & SMOKE DAMPERS	1999	9,527						21
22	PROCARE 1000 NURSE CALL	1999	17,494						22
23	ZSN REPAIR	1999	1,307						23
24	DRAIN REPLACEMENT	2000	875						24
25	DRYWALL REPAIR	2000	600						25
26	CONTROL PANEL REPLACED	2000	984						26
27	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						27
28	WALLCOVERINGS	2000	364						28
29	VINYL WALLCOVERINGS	2000	1,662						29
30	WALLCOVERING	2000	1,566						30
31	CLOSET DOORS	2000	13,140						31
32	WALLCOVERING	2000	37						32
33	WALLCOVERING - DINING RM	2000	1,769						33
34	TOTAL (lines 1 thru 33)		\$ 2,521,510	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,521,510	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						2
3	CORNER GUARDS	2000	17						3
4	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						4
5	WALLCOVERING	2000	270						5
6	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						6
7	C/R 5/31/03 AUDIT ADJ #1a - Developers Cost	2000	(4,708)						7
8	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						8
9	VCT	2000	3,230						9
10	WIRING - ACTIVITY & REC RM	2000	1,412						10
11	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						11
12	PAINTING CLOSET DOORS	2000	8,000						12
13	SINK, FAUCET & PLUMBING	2000	1,985						13
14	ARCADIA HALL BATH	2000	3,933						14
15	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						15
16	CLOSET DOORS	2000	7,640						16
17	SHOWER-CERAMIC TILE	2000	302						17
18	CLOSET DOOR - RETAINAGE	2000	1,460						18
19	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						19
20	2 NURSE STATIONS	2001	12,826						20
21	BORDER	2001	210						21
22	VCT	2001	1,130						22
23	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						23
24	DOORS	2001	8,985						24
25	CARPET	2001	1,053						25
26	CEILING TILE	2001	28,650						26
27	SHOWER RENOVATION	2001	13,048						27
28	PAINTING	2001	765						28
29	COURTYARD RENOVATIONS	2001	4,775						29
30	COURTYARD RENOVATIONS	2001	5,120						30
31	DOORS	2002	746						31
32	CARPET	2002	995						32
33	WALL TILE FOR SHOWER	2002	1,840						33
34	TOTAL (lines 1 thru 33)		\$ 2,645,205	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	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		\$ 2,645,205	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2 MILLWORK, ELECTRICAL	2002	14,351						2
3 CARPET	2002	1,686						3
4 Freight on Carpet	2002	73						4
5 VWC	2002	282						5
6 3 Heavy Duty Doors	2002	3,574						6
7 C/R 5/31/03 AUDIT ADJ #1b - Overhead & Interest	2002	(5,444)						7
8 Painting, VWC, and Flooring	2002	1,098						8
9 Painting, VWC, and Flooring	2002	524						9
10 Renovation - Electrical 5/31/03 Audit Adj #2a Change Year	2002	87,505						10
11 Arch Engineering Costs	2002	1,018						11
12 freight on vwc	2002	9						12
13 general construction	2002	1,169						13
14 Freight on Carpet	2002	112						14
15 Carpet	2002	1,170						15
16 border	2002	1,254						16
17 freight on vwc	2002	20						17
18 carpet	2002	953						18
19 carpet and installation	2002	16,878						19
20 VWC	2002	140						20
21 carpet	2002	953						21
22 paint, vwc, and flooring	2002	9,357						22
23 Retro Addition	2002	(231)						23
24 VWC	2003	2,980						24
25 Flooring	2003	445						25
26 Reno - Gen, fire, Doors&P Audit Adj #2b Change Yr 2001 & 2002	2003	60,845						26
27 C/R 5/31/03 AUDIT ADJ #2b - Overhead & Interest	2003	(60,845)						27
28 Renovation - 5/31/03 Audit Adj #2b Change Year 2001	2001	88,776						28
29 Renovation - 5/31/03 Audit Adj #2b Change Year 2002	2002	6,593						29
30 Arch Engineering Costs	2003	172						30
31 Arch Engineering Costs	2003	774						31
32 Carpet	2003	140						32
33 CARPET	2003	1,075						33
34 TOTAL (lines 1 thru 33)		\$ 2,882,610	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	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	\$ 2,882,610	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2	ELEVATORS - OVERHEAD AND INTEREST	20033,300						2
3	ELEVATORS CARPENTRY	200372,624						3
4	BORDERS	2003127						4
5	VWC	2003438						5
6	VWC	20034,080						6
7	VWC	2003571						7
8	CARPET AND INSTALLATION	20034,190						8
9	SHOWER ROOM FLOORS AND WALLS	20036,901						9
10	SHOWER ROOM FLOORS AND WALLS	2003289						10
11	DEVELOPERS COSTS - OVERHEAD	200417,971						11
12	DEVELOPERS COSTS - INTEREST	20041,099						12
13	CARPETING AND PADS	20047,249						13
14	WALLCOVERINGS	200446,392						14
15	EXTERIOR LIGHT POLE	20046,596						15
16	EXTERIOR LIGHT POLE	2004687						16
17	CONCRETE SLAB	20053,115						17
18	VINYL WALL COVERING	20041,377						18
19	VINYL WALL COVERING AND PAINTING	20049,000						19
20	VINYL WALL COVERING	2004938						20
21	VINYL WALL COVERING & PAINTING	20041,380						21
22	VINYL WALL COVERING & PAINTING	20043,420						22
23	COVE BASE	20042,160						23
24	DOORS	20045,893						24
25	CARPET	20044,275						25
26	INSTALL SECURITY DOOR	20052,910						26
27	FOURTEEN ARTWORK PIECES	20041,117						27
28	ELECTRICAL WORK	20055,926						28
29	STAIR TREDS	20055,640						29
30	OVERHEAD	200513,558						30
31	INTEREST	2005805						31
32	FLOORING	20058,770						32
33	WALL COVERING	20058,050						33
34	TOTAL (lines 1 thru 33)	\$ 3,133,458	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	34

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

Facility Name & ID Number Heartland of Champaign IL, LLC

0049395

Report Period Beginning:

06/01/10

Ending:

05/31/11

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 12E, Carried Forward		\$ 3,133,458	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2	CARPENTRY	2005	1,012						2
3	FENCE	2006	5,140						3
4	FENCE	2006	882						4
5	CERAMIC TILE SHOWER	2006	3,949						5
6	CHAMPAIGN IL	2007	2,550						6
7	SIDEWALK	2008	11,430						7
8	Blgd Im - Arch & Eng Fees	2007	53,414						8
9	Blgd Im - Arch & Eng Fees	2007	205,493						9
10	WALLPAPER	2007	6,605						10
11	CEILING TILES	2007	22,683						11
12	ENGINEERING	2007	17,000						12
13	ROOF REPLACEMENT	2007	66,406						13
14	COMMON AREA FURNISHINGS	2007	316						14
15	COMMON AREA FURNISHINGS	2008	1,605						15
16	CARPET FOR 2ND/3RD FLOOR	2008	26,122						16
17	CARPET FOR 2ND/3RD FLOOR	2008	(1)						17
18	FIRE DAMPERS	2008	75,045						18
19	Renov -(Tot contracted amt) -Painting, Drywall, VWC	2009	10,350						19
20	CARPETING+PADS	2008	9,317						20
21	PAVING/SEALCOATING	2008	5,949						21
22	SEWER LINE	2009	13,911						22
23	Add'l cost Fire Dampers	2008	5,587						23
24	Fire Dampers	2008	50,285						24
25	Kitchen Storage Room Door	2009	5,283						25
26	0310 Renov - General Overhead & Interest	2010	128						26
27	0310 Renov - Carpentry - Subcontr	2010	98,201						27
28	0310 Renov - Carpeting & Pads	2010	12,368						28
29	0310 Renov - Wallcovering & Corner Guards	2010	30,901						29
30	ceramic floors	2010	3,105						30
31	exterior doors	2010	32,279						31
32	0310 Renov - Carpentry - Subcontr additional	2010	178,913						32
33	85- gal water heater	2011	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 4,100,348	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	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		\$ 4,100,348	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	1
2 fabric	2011	653						2
3 Frt on Fabric	2011	125						3
4 Wallcovering	2011	1,761						4
5 vinyl fencing	2010	7,875						5
6 Additional cost for vinyl fencing	2010	7,875						6
7 Frt on carpet	2011	1,013						7
8 carpeting	2011	6,910						8
9 2010 Renov - Carpentry - Subcontr - Central Bath	2011	48,222						9
10 Painting	2011	8,123						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,182,905	\$ 169,410		\$ 169,410	\$	\$ 3,531,127	34

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

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	\$1,599,196	\$112,723	\$112,723	\$		\$1,329,925	71
72	Current Year Purchases	108,407						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			12,464	12,464			74
75	TOTALS	\$1,707,603	\$112,723	\$125,187	\$12,464		\$1,329,925	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	2	
	Reference	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)	\$6,194,494	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$282,133	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$294,597	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12,464	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,861,052	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$79,336
- Description:02 Concentrators, Wheelchairs, Geri Chairs, Elec. 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		\$	\$18,003	17
18					18
19					19
20					20
21	TOTAL		\$	\$18,003	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)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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.)

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	3022	hrs	\$ 114,955	934	\$ 51,001	\$ 2,668	3,956	\$ 168,624	1	
2	Licensed Speech and Language Development Therapist	10a	2897	hrs	110,190			721	2,897	110,911	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	7108	hrs	270,330			10,216	7,108	280,546	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				382,979		382,979	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): Inhalation Therapist					797	43,542		797	43,542	12	
13	Other (specify): IV Ther/X-Ray/Lab	43, 2 & 3					115,560	61,373		176,933	13	
14	TOTAL				\$ 495,475	1,731	\$ 210,103	\$ 457,957	14,758	\$ 1,163,535	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	\$ 44,257	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (440,674))	1,411,970		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,120		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,459,347	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,986		13
14	Buildings, at Historical Cost	4,182,905		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,707,603		16
17	Accumulated Depreciation (book methods)	(4,861,052)		17
18	Deferred Charges	3,797,772		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)	\$ 5,131,214	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,590,561	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 140,656	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	469,903		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,982		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,661		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	49,972		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 786,174	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,802,786		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	21		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,802,807	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,588,981	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,998,420)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,590,561	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$970,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$970,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	767,615	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)	\$767,615	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(7,736,700)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$(7,736,700)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$(5,998,420)	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	\$ 10,112,888	1
2	Discounts and Allowances for all Levels	(3,072,974)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,039,914	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,178,434	6
7	Oxygen	(88)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,178,346	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	725	12
13	Barber and Beauty Care	8,990	13
14	Non-Patient Meals	9,830	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	401,185	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	183,649	19
20	Radiology and X-Ray	312,471	20
21	Other Medical Services	44,012	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 960,862	23
	D. Non-Operating Revenue		
24	Contributions	215	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 215	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)	\$ 10,179,337	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,313,301	31
32	Health Care	4,340,777	32
33	General Administration	2,498,994	33
	B. Capital Expense		
34	Ownership	562,060	34
	C. Ancillary Expense		
35	Special Cost Centers	640,745	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,411,722	40
41	Income before Income Taxes (line 30 minus line 40)**	767,615	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 767,615	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	2,991	3,711	\$ 115,512	\$ 31.13	1
2	Assistant Director of Nursing	6,872	8,525	226,660	26.59	2
3	Registered Nurses	18,225	22,606	591,368	26.16	3
4	Licensed Practical Nurses	23,739	29,447	610,466	20.73	4
5	CNAs & Orderlies	75,971	94,420	1,127,238	11.94	5
6	CNA Trainees					6
7	Licensed Therapist	13,027	14,349	545,774	38.04	7
8	Rehab/Therapy Aides	13,883	15,293	380,992	24.91	8
9	Activity Director	5,698	6,279	79,280	12.63	9
10	Activity Assistants					10
11	Social Service Workers	7,053	7,768	146,045	18.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,298	22,367	255,434	11.42	15
16	Dishwashers					16
17	Maintenance Workers	4,398	4,846	88,639	18.29	17
18	Housekeepers	9,266	10,211	116,781	11.44	18
19	Laundry	3,696	4,077	55,571	13.63	19
20	Administrator	2,080	2,080	51,087	24.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,944	15,278	271,140	17.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,568	3,932	57,951	14.74	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	3,789	4,177	52,677	12.61	33
34	TOTAL (lines 1 - 33)	228,498	269,366	\$ 4,772,615 *	\$ 17.72	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	47,563	9, 3	36
37	Medical Records Consultant	Monthly	2,390	10, 3	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) Medical Svcs	Monthly	164,849	10, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 214,802		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	1,461	36,268	10, 3	52
53	TOTAL (lines 50 - 52)	1,461	\$ 36,268		53

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

** See instructions.

****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.

ICHA \$3,726

(3)

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

YES

If YES, have these costs been properly adjusted out of the cost report?

YES_\$6604

(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.

\$

44,414

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.

\$

55,845

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.

\$

9,830

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

NO

Attach invoices and a summary of services for all architect and appraisal fees.