

		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>0049544</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heartland of Decatur IL, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/10</u> to <u>05/31/11</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>444 West Harrison</u> <u>Decatur</u> <u>62526</u>																									
Number City Zip Code																									
County: <u>Macon</u>																									
Telephone Number: <u>(217) 877-7333</u> Fax # <u>(217) 872-6723</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) _____														
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	(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>11/01/81</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 _____	_____
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	☐ 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>Gary Geise</u> Telephone Number: <u>(419) 252-5731</u>																									
Email Address: _____																									

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544 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>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</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>112</u>	TOTALS	<u>112</u>	<u>40,880</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>7,389</u>	<u>16,833</u>	<u>12,567</u>	<u>36,789</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>7,389</u>	<u>16,833</u>	<u>12,567</u>	<u>36,789</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.99%

D. How many bed-hold days during this year were paid by the Department?

4 (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 112 and days of care provided 11,381

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: 05/31

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

Facility Name & ID Number Heartland of Decatur IL, LLC # 0049544 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	280,804	27,483	74,350	382,637	6,902	389,539		389,539			1
2	Food Purchase		296,972		296,972		296,972	(253)	296,719			2
3	Housekeeping	144,604	20,974	13,501	179,079		179,079		179,079			3
4	Laundry	48,544	28,431	1,523	78,498		78,498		78,498			4
5	Heat and Other Utilities			157,457	157,457	1,861	159,318		159,318			5
6	Maintenance	47,862	23,459	138,340	209,661		209,661		209,661			6
7	Other (specify):* Medical Waste			2,089	2,089		2,089		2,089			7
8	TOTAL General Services	521,814	397,319	387,260	1,306,393	8,763	1,315,156	(253)	1,314,903			8
	B. Health Care and Programs											
9	Medical Director			39,600	39,600		39,600		39,600			9
10	Nursing and Medical Records	2,465,111	190,259	72,773	2,728,143	8,187	2,736,330		2,736,330			10
10a	Therapy	852,864	10,883	29,657	893,404		893,404		893,404			10a
11	Activities	83,693	7,220	6,518	97,431		97,431		97,431			11
12	Social Services	123,133	4,110	3,599	130,842		130,842		130,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,524,801	212,472	152,147	3,889,420	8,187	3,897,607		3,897,607			16
	C. General Administration											
17	Administrative	75,050		386,894	461,944	(92,495)	369,449		369,449			17
18	Directors Fees											18
19	Professional Services			12,235	12,235		12,235	(12,235)				19
20	Dues, Fees, Subscriptions & Promotions			99,059	99,059		99,059	(24,014)	75,045			20
21	Clerical & General Office Expenses	334,945	50,310	5,506	390,761		390,761	37,158	427,919			21
22	Employee Benefits & Payroll Taxes			803,030	803,030	31,442	834,472		834,472			22
23	Inservice Training & Education			3,573	3,573		3,573		3,573			23
24	Travel and Seminar			21,197	21,197		21,197		21,197			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			317,897	317,897		317,897		317,897			26
27	Other (specify):*							(2,736)	(2,736)			27
28	TOTAL General Administration	409,995	50,310	1,649,391	2,109,696	(61,053)	2,048,643	(1,827)	2,046,816			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,456,610	660,101	2,188,798	7,305,509	(44,103)	7,261,406	(2,080)	7,259,326			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			292,262	292,262	10,901	303,163		303,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			183,089	183,089	33,202	216,291	(184,515)	31,776			32
33	Real Estate Taxes			96,268	96,268		96,268		96,268			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,747	31,747		31,747		31,747			35
36	Other (specify):*											36
37	TOTAL Ownership			603,366	603,366	44,103	647,469	(184,515)	462,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,306	1,100	275,406		275,406		275,406			39
40	Barber and Beauty Shops			19,181	19,181		19,181		19,181			40
41	Coffee and Gift Shops	552			552		552		552			41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* IV X-Ray & Lab		33,101	60,094	93,195		93,195		93,195			43
44	TOTAL Special Cost Centers	552	307,407	141,695	449,654		449,654		449,654			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,457,162	967,508	2,933,859	8,358,529		8,358,529	(186,595)	8,171,934			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	(253)	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	(673)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,736)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,650)	21		18
19	Entertainment				19
20	Contributions	(1,970)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,235)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	87,123	21		24
25	Fund Raising, Advertising and Promotional	(24,014)	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	(218,187)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,595)		\$	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))	\$ (186,595)		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

ID#

0049544

Report Period Beginning:

06/01/10

Ending:

05/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (25,375)	21	1
2	Employee benefits - Marketing	(6,939)	21	2
3	HCP Lease Interest	(184,515)	32	3
4	Vending Income	(1,358)	21	4
5	Misc. Income	0	21	5
6	Activity 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
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34				34
35				35
36				36
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(218,187)		49

Summary A

05/31/11

[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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	Home Office Allocation	\$ 386,894	HCR Manor Care Services, LLC	100.00%	\$ 386,894	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,457,162	Heartland Employment Services, LLC	100.00%	4,457,162		4
5	V	10a	Therapy Management	6,825	Heartland Rehabilitation Services, LLC	100.00%	6,825		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			\$ 4,850,881			\$ 4,850,881	\$ *	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 Champaign IL, LLC	Champaign				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 (SNF), L	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 IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) 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
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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 Decatur IL, LLC # 0049544 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 St.
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	7,591,775	\$ 6,902	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	7,591,775	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	7,591,775	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	7,591,775	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	7,591,775	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	7,591,775	1,861	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	7,591,775	7,026	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	7,591,775	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	7,591,775	1,161	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	7,591,775	64,384	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	1,871,124	5,027,701	7,591,775	20,508	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	7,591,775	209,507	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	7,591,775	18,972	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	7,591,775	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	7,591,775	12,470	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	7,591,775	744	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	7,591,775	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	7,591,775	10,157	18
19										19
20	32	Directly Assigned Interest				12,736,052			33,202	20
21		Non Central Division Nursing Home Allocation				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 386,894	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			\$ 738,560	\$ 738,560		4.4955	\$ 33,202	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income Other										(1,426)	8	
9	TOTAL Facility Related						\$ 738,560	\$ 738,560			\$ 31,776	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 738,560	\$ 738,560			\$ 31,776	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

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.	\$	87,857	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.)			\$	95,994	2
3. Under or (over) accrual (line 2 minus line 1).			\$	8,137	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	88,131	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.			\$	96,268	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	78,410	8	
		2007	82,264	9	
		2008	83,923	10	
		2009	95,844	11	
		2010	96,143	12	
Line 2: \$95,994 = \$47,922 for the 2nd half of 2009 + 48,072 for the 1st half of 2010.					
Line 4: \$88,131 = \$48,071 2nd half 2010 + \$40,060 estimate for Jan-May 2011.					

FOR BHF USE ONLY		
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 Heartland of Decatur IL, LLC COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0049544

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.

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:

37,542

B. General Construction Type:

ExteriorMasonry

FrameSteel

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1981, 2005, 2006	\$ 411,449	1
2	Facility		2009	45,126	2
3	TOTALS			\$ 456,575	3

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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	96			1963	\$ 659,655	\$ 62,921		\$ 62,921	\$	2,211,232	4
5	6			2002	480,558						5
6				2005	1,072,957						6
7	7/1/06 Capital Rate Adj #1			2005	259,992						7
8	Therapy addition			2009	743,129						8
	Improvement Type**										
9	Current Year Depreciation					125,152		125,152		1,949,569	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15	RETIREMENTS			1987	(86,079)						15
16				1988	38,377						16
17				1989	18,196						17
18				1990	6,261						18
19				1991	162,665						19
20	RETIREMENTS			1991	(3,037)						20
21				1992	121,887						21
22	RETIREMENTS			1992	(6,084)						22
23				1993	191,712						23
24				1994	75,641						24
25				1995	47,351						25
26	A/C WALL SLEEVE UNIT			1995	2,952						26
27	INSTALL FIRE BOXES			1995	513						27
28	ELECTRICAL			1995	7,058						28
29	HANDRAILS			1995	8,442						29
30	CONCRETE FLOOR			1995	884						30
31	ARCHITECT-ARCADIA / LOBBY			1995	1,439						31
32	LIGHTING			1995	4,074						32
33	FLOORING			1995	2,080						33
34	NURSE CALL SYSTEM			1995	38,400						34
35	DOOR LOCKS			1995	698						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

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	UPGRADE ARCADIA / LOBBY	1996	\$ 10,460	\$		\$	\$	37
38	WALL VINYL	1996	2,759					38
39	HANDRAILS	1996	9,792					39
40	CAPITALIZED LABOR-ARCADIA / LOBBY	1996	7,272					40
41	5/31/99 AUDIT ADJUSTMENT	1996	(7,272)					41
42	REMODELING-ARCADIA / LOBBY	1996	2,466					42
43	INSTALL FIRE DOORS	1996	8,340					43
44	PHONE WIRING/JACKS	1996	1,486					44
45	SIGNS/BOARDS	1996	952					45
46	A/C WORK	1996	3,237					46
47	ELECTRICAL-ARCADIA / LOBBY	1996	3,479					47
48	INSTALL TILES	1996	1,825					48
49	INSTALL ASPHALT	1996	4,390					49
50	WALL COVERINGS	1997	3,715					50
51	ROOFTOP TRANE UNITS	1997	12,448					51
52	INSTALL TILES/CEILING & WALL PANELS	1997	7,385					52
53	INSTALL WATER HEATER	1997	7,010					53
54	REPAIR ROOF LEAKS	1997	1,500					54
55	ELECTRICAL	1997	1,549					55
56	INSTALL DOORS	1997	12,737					56
57	WALL COVERINGS	1997	1,623					57
58	INSTALL VINYL TILE	1997	11,728					58
59	A/C COMPRESSOR WORK	1997	2,257					59
60	FACILITY PLAN ALLOC	1997	2,759					60
61	5/31/99 AUDIT ADJUSTMENT	1997	(2,759)					61
62	REPAIR WATER LEAKS	1997	1,408					62
63	NURSES STATION GATE	1997	625					63
64	LANDSCAPING	1997	828					64
65	SIDEWALK	1997	4,023					65
66	INSTALL PATIO COVERS	1997	1,082					66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 4,183,015	\$ 188,073		\$ 188,073	\$ 4,160,801	70

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

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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		\$ 4,183,015	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	ROOFING	1998	1,992						2
3	HVAC	1998	3,794						3
4	TILE & CARPET	1998	6,771						4
5	FINISH/STUD	1998	3,333						5
6	MASONRY WORK	1998	1,333						6
7	PLUMBING	1998	3,172						7
8	PAINTING/WALLCOVERINGS	1998	2,182						8
9	ELECTRICAL WORK	1998	2,352						9
10	CORPORATE OVERHEAD	1998	1,702						10
11	5/31/99 AUDIT ADJUSTMENT	1998	(1,702)						11
12	SECURITY SYSTEM	1998	22,488						12
13	IDPU PLAN REVIEW	1998	1,362						13
14	DOORS/WINDOWS	1998	2,681						14
15	GENERAL CONTRACTOR FEES	1998	1,973						15
16	FINISH/STUD	1998	9,004						16
17	MASONRY WORK	1998	21,533						17
18	FLOORING	1998	5,943						18
19	PAINTING/WALLCOVER	1998	9,311						19
20	PLUMBING	1998	1,183						20
21	ROOFING	1998	41,500						21
22	GENERAL CONTRACTORS FEES	1998	4,278						22
23	DOORS/WINDOWS	1998	3,634						23
24	ELECTRICAL	1998	1,333						24
25	HVAC	1998	5,359						25
26	SIGNAGE	1998	11,862						26
27	WALLCOVERING	1999	18,122						27
28	FLOORING	1999	1,600						28
29	WATER HEATER	1999	1,089						29
30	CARPET	1999	2,769						30
31	LEONARD MIXING VALVE	1999	3,236						31
32	FLOOR COVERING	1999	1,552						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,379,756	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	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		\$ 4,379,756	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	FREIGHT CARPET TILES	1999	214						2
3	BUILDING DECORATIONS	1999	23						3
4	BATH STATION TRANSFORMER	1999	3,355						4
5	MJ ROST FREIGHT	1999	616						5
6	WALLCOVERING	1999	1,325						6
7	CORNERGUARD	1999	270						7
8	BOILER	2000	3,076						8
9	CONCRETE & CARPENTRY	2000	30,863						9
10	PAINTING	2000	49,231						10
11	PLUMBING	2000	14,039						11
12	PLUMBING-2003 AUDIT ADJUSTMENT	2000	(6,908)						12
13	DEVELOPERS COST-10 BED ADDTN	2000	116,845						13
14	DEVELOPERS COST-2003 AUDIT ADJUSTMENT	2000	(116,845)						14
15	ADDTL COST ON CONSTRUCTION-10 BED ADDTN	2000	1,938						15
16	CARPET INSTALLATION V#3504	2000	1,805						16
17	CEILING / FLOORING	2000	25,652						17
18	AWNING FRONT ENT / SERVICE ENT	2000	2,013						18
19	CLOSET DOOR	2000	350						19
20	B G ASSEMBLY	2001	487						20
21	B G ASSEMBLY	2001	321						21
22	B G ASSEMBLY	2001	776						22
23	WATER HEATER	2001	8,452						23
24	WATER HEATER	2001	7,755						24
25	WATER HEATER - 2003 AUDIT ADJUSTMENT	2001	(500)						25
26	VINLY WALL COVERING	2001	434						26
27	AWNING	2001	2,013						27
28	VINLY WALL COVERING	2001	62						28
29	Border	2001	244						29
30	VWC	2001	316						30
31	Wall Coverings	2001	277						31
32	VWC	2001	200						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,528,455	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	34

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

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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 12C, Carried Forward		\$ 4,528,455	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	Painting	2001	7,218						2
3	Window Treatments	2001	648						3
4	CARPET	2001	1,629						4
5	Light Fixtures	2001	3,404						5
6	Carpet	2001	870						6
7	Handrails	2001	1,865						7
8	Add'l Cost Smoke Shelter	2001	3,960						8
9	Smoke Shelter	2001	2,015						9
10	Painting	2001	7,200						10
11	Painting	2001	2,602						11
12	Add'l Cost Smoke Shelter	2001	600						12
13	Double Glass Doors	2001	4,050						13
14	Vinyl Tile & Sheets	2001	7,759						14
15	Wallpaper & Painting Retainage	2001	500						15
16	Wallpaper & Painting	2001	4,500						16
17	Doors	2001	4,935						17
18	Smoking Shelter	2001	5,400						18
19	VWC	2001	823						19
20	Smoke Shelter	2001	3,492						20
21	Artwork	2001	2,068						21
22	ARTWORK - 2003 AUDIT ADJUSTMENT	2001	(2,068)						22
23	Smoke Shelter	2001	388						23
24	Carpet	2001	8,821						24
25	Smoke Shelter	2001	400						25
26	Smoke Shelter	2001	988						26
27	Window treatments	2001	593						27
28	Kitchen store room door	2001	1,380						28
29	Sidewalk & Parking Lot	2001	8,555						29
30	Entrance Double Door	2001	1,305						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,614,355	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	34

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

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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 12D, Carried Forward		\$ 4,614,355	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	Shower Room Renovation	2002	655						2
3	Window treatments	2002	3,459						3
4	Carpet and Installation	2002	1,190						4
5	Artwork	2002	2,199						5
6	ARTWORK - 2003 AUDIT ADJUSTMENT	2002	(2,199)						6
7	Renovation - OH & Int.	2002	1,905						7
8	RENOVATION-2003 AUDIT ADJUSTMENT	2002	(1,905)						8
9	Reno - Flooring, Painting	2002	29,775						9
10	Reno - Plumbing & Electrical	2002	37,536						10
11	Arch & Engineering Costs	2002	2,240						11
12	Arch & Engineering Costs	2002	619						12
13	Exterior Renovations - Soffitt & Gutters	2002	9,112						13
14	7/1/06 CAPITAL RATE ADJ #2	2002	(142)						14
15	Exterior Renovations - Soffitt & Gutters	2002	1,013						15
16	Vent Work	2002	331						16
17	Baseboard	2002	4,164						17
18	Adjust asset #1680 - (Reno-Plumbing & Electrical)	2002	(4,164)						18
19	Addn. - Carpet, VWC & Sig	2002	9,213						19
20	Addn - Concrete test & L	2002	3,599						20
21	Addtn - Permits	2002	8,834						21
22	Renovation-Roofing & Sheet Metal	2003	67,148						22
23	Renovation-General Overhead	2003	1,031						23
24	7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						24
25	Renovation-Interest	2003	581						25
26	7/1/06 CAPITAL RATE ADJ #4	2003	(581)						26
27	AWNING	2003	2,470						27
28	Landscaping-Install Façade Materials	2003	23,984						28
29	GAZEBO	2003	6,215						29
30	ADD'L COST GAZEBO	2003	2,611						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,824,217	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	34

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

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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		\$ 4,824,217	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	Renovation-Engineering	2004	4,880						2
3	Renovation-General Overhead	2004	10,453						3
4	7/1/06 Capital Rate Adj #5	2004	(10,453)						4
5	Renovation-Interest	2004	138						5
6	7/1/06 Capital Rate Adj #6	2004	(138)						6
7	Doors and Downspouts	2004	7,110						7
8	Doors Retainage	2004	790						8
9	Vinyl Tile and Cove Base	2004	17,910						9
10	Vinyl Tile and Base	2005	2,974						10
11	7/1/06 Capital Rate Adj #7	2005	(2,974)						11
12	Vinyl Tile	2005	2,974						12
13	7/1/06 Capital Rate Adj #7	2005	(2,974)						13
14	Vinyl Tile and Cove Base	2005	10,985						14
15	Water/Sewer/Utilities	2005	76,296						15
16	7/1/06 Capital Rate Adj #8	2005	(76,296)						16
17	Paving/Parking	2005	45,064						17
18	7/1/06 Capital Rate Adj #9	2005	(45,064)						18
19	Site Concrete	2005	20,963						19
20	7/1/06 Capital Rate Adj #10	2005	(20,963)						20
21	Site Preparation	2005	50,580						21
22	7/1/06 Capital Rate Adj #11	2005	(50,580)						22
23	Fencing/Gazebo/Courtyard	2005	13,234						23
24	7/1/06 Capital Rate Adj #12	2005	(13,234)						24
25	Landscaping	2005	30,808						25
26	7/1/06 Capital Rate Adj #13	2005	(30,808)						26
27	Site Demolition	2005	25,400						27
28	7/1/06 Capital Rate Adj #17	2005	(25,400)						28
29	Water/Sewer Testing	2005	9,025						29
30	Landscaping	2005	10,269						30
31	7/1/06 Capital Rate Adj #14	2005	(10,269)						31
32	Landscaping	2005	1,838						32
33	7/1/06 Capital Rate Adj #15	2005	(1,838)						33
34	TOTAL (lines 1 thru 33)		\$ 4,874,917	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	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	\$ 4,874,917	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	Nursing Station Carpentry	2005	3,360					2
3	Vinyl Wall Covering	2005	1,344					3
4	Architect & Engineering Fees	2005	150,302					4
5	7/1/06 Capital Rate Adj #18	2005	(13,833)					5
6	General Overhead & Interest	2005	221,331					6
7	7/1/06 Capital Rate Adj #19	2005	(221,331)					7
8	Permit Fees, Plan Reviews	2005	15,128					8
9	7/1/06 Capital Rate Adj #16	2005	(9,600)					9
10	Vinyl Wall Covering, Flooring	2005	34,342					10
11	Vinyl Wall Covering	2005	1,551					11
12	Carpet	2005	3,680					12
13	Canopy Sprinklers	2005	3,950					13
14	Blinds	2005	2,375					14
15	Vinyl Wall Covering	2005	(676)					15
16	Fabrics	2005	498					16
17	Flooring	2005	14,253					17
18	Overhead & Interest	2005	1,641					18
19	7/1/06 Capital Rate Adj #20	2005	(1,641)					19
20	Carpentry	2005	26,507					20
21	Wallcovering	2006	624					21
22	Doors	2006	5,715					22
23	HVAC	2006	16,890					23
24	Painting	2006	2,325					24
25	Rooftop Unit	2006	10,910					25
26	Demolish & Reinstall Floors	2006	30,700					26
27	Ductwork	2006	1,163					27
28	Electrical	2006	4,176					28
29	Wallcovering, Painting	2006	2,187					29
30	Fence	2006	9,983					30
31	ENGINEERING FOR ENTRANCE	2007	1,425					31
32	EXTERIOR SIGN	2008	4,344					32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,198,540	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	34

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

Facility Name & ID Number Heartland of Decatur IL, LLC

0049544

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 12G, Carried Forward		\$ 5,198,540	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	1
2	SEWER LINE	2008	707						2
3	SEWER LINE	2008	6,364						3
4	0407 RESI RM CORR OFFICE RENO	2008	7,619						4
5	0407 RESI RM CORR OFFICE RENO	2008	39,580						5
6	3 TON UNIT	2008	4,358						6
7	100 AMP PANEL	2008	1,986						7
8	ADJ HOT WATER SYS (ASSET 1903)	2008	7,947						8
9	1308 2 HOT WATER SYSTEM	2008	2,078						9
10	1308 2 HOT WATER SYSTEM	2008	302						10
11	1308 2 HOT WATER SYSTEM	2008	73,200						11
12	PT, BLD IM - ARCH, ENG & DEV COSTS	2009	120,617						12
13	PT, BLD IM - DEV GENL O-H	2009	54,958						13
14	PT, BLD IM - INT ON CONSTRUCTION	2009	13,277						14
15	PT, BLD IM - CARPET & PADS	2009	1,847						15
16	PT, BLD IM - WALL COVERINGS	2009	7,844						16
17	RETAINING WALL	2008	2,900						17
18	PAVING/SEALCOATING	2008	6,210						18
19	PT, LI - DEV COSTS	2009	44,176						19
20	PT, LI - GEN'L CONTRACTOR	2009	116,991						20
21									21
22	PT Addition - GEN'L CONTRACTOR	2009	13,771						22
23	PT Addition - Arch & Eng. Costs	2009	3,719						23
24	PT Addition - Wallcovering & Guards	2009	583						24
25	PT Addition - Electrical	2009	7,390						25
26	PT Addition - Arch & Eng. Costs	2009	962						26
27									27
28	Fire proof Mechanical room ceiling	2010	8,881						28
29	Carpet	2010	6,879						29
30	VWC & Paint	2010	23,000						30
31	Heater	2011	1,661						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,778,347	\$ 188,073		\$ 188,073	\$	\$ 4,160,801	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	\$1,693,218	\$104,189	\$104,189	\$		\$1,432,523	71
72	Current Year Purchases	121,931						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			10,901	10,901			74
75	TOTALS	\$1,815,149	\$104,189	\$115,090	\$10,901		\$1,432,523	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)	\$8,050,071	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$292,262	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$303,163	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,901	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,593,324	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: \$31,747
- Description:02 Concentrators, Wheelchairs, Gerichairs, Elct. 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.)

	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, 1	2,660	hrs	\$ 101,329		\$	248	2,660	\$ 101,577	1	
2	Licensed Speech and Language Development Therapist	10a, 1	5,382	hrs	205,012			2,016	5,382	207,028	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a, 1	4,925	hrs	187,624			8,619	4,925	196,243	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				274,306		274,306	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): IV Therapy	43, 2						33,101		33,101	12	
13	Other (specify): X-Ray & Lab	43, 3					60,094			60,094	13	
14	TOTAL				\$ 493,965		\$ 60,094	\$ 318,290	12,967	\$ 872,349	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	\$ 10,493	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 204,655)	751,505		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,426		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 765,424	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,575		13
14	Buildings, at Historical Cost	5,778,347		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,815,149		16
17	Accumulated Depreciation (book methods)	(5,593,324)		17
18	Deferred Charges	19,399,353		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): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,856,100	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,621,524	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,817	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	484,108		30
31	Accrued Taxes Payable (excluding real estate taxes)	74,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,131		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	22,914		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 801,129	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,305,576		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)	\$ 19,305,597	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 20,106,726	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,514,798	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 22,621,524	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$2,323,350	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$2,323,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,353,410	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$1,353,410	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(1,161,962)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$(1,161,962)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$2,514,798	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	\$ 9,656,170	1
2	Discounts and Allowances for all Levels	(2,248,925)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,407,245	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,818,117	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,818,117	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	2,791	12
13	Barber and Beauty Care	16,903	13
14	Non-Patient Meals	253	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	328,542	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,388	19
20	Radiology and X-Ray	37,890	20
21	Other Medical Services	37,845	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 485,612	23
	D. Non-Operating Revenue		
24	Contributions	970	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts	(5)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (5)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,711,939	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,306,393	31
32	Health Care	3,889,420	32
33	General Administration	2,109,696	33
	B. Capital Expense		
34	Ownership	603,366	34
	C. Ancillary Expense		
35	Special Cost Centers	388,334	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,358,529	40
41	Income before Income Taxes (line 30 minus line 40)**	1,353,410	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,353,410	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	2,377	2,583	\$ 91,107	\$ 35.27	1
2	Assistant Director of Nursing	4,653	5,056	144,775	28.63	2
3	Registered Nurses	15,734	17,096	456,085	26.68	3
4	Licensed Practical Nurses	27,093	29,438	604,040	20.52	4
5	CNAs & Orderlies	87,022	94,727	1,146,876	12.11	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,968	14,084	536,486	38.09	7
8	Rehab/Therapy Aides	11,249	12,217	316,378	25.90	8
9	Activity Director	6,726	7,313	83,693	11.44	9
10	Activity Assistants					10
11	Social Service Workers	6,239	6,790	123,133	18.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,447	26,587	280,804	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,242	2,440	47,862	19.62	17
18	Housekeepers	12,261	13,338	144,604	10.84	18
19	Laundry	4,482	4,875	48,544	9.96	19
20	Administrator	2,080	2,080	75,050	36.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,514	16,815	302,631	18.00	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	1,712	1,862	22,228	11.94	31
32	Other Health Care(specify)					32
33	Other(specify)	40	43	552	12.84	33
34	TOTAL (lines 1 - 33)	236,839	257,344	\$ 4,424,848 *	\$ 17.19	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	39,600	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	157	7,899	10, 1	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)	157	\$ 47,499		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	108	\$ 5,814	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides	898	13,765	10, 3	52
53	TOTAL (lines 50 - 52)	1,006	\$ 19,579		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeartland of Decatur IL, LLC# 0049544Report Period Beginning:06/01/10Ending:05/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Cassella (Jul. '10 - May '11)	Administrator	0	\$ 72,671
Jason Gill (June '10)	Administrator	0	2,379
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,050

B. Administrative - Other

Description	Amount
Various home office services	\$ 386,894
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Littler Mendelson PC	Legal Fees	2,500
Michael T. Mahoney, LTD	Legal Fees	9,108
United Collection Bureau Inc.	Collection Services	627
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 12,235

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 73,565
Unemployment Compensation Insurance	56,427
FICA Taxes	312,505
Employee Health Insurance	318,058
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	34,409
Appreciation, Other Benefits & Marketing Adjust	(4,870)
Tuition Program	245
SMSP Match & RSU	35
Employee Uniforms	12,656
Home Office Allocation	31,442
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	54,967
Health Care Worker Background Check (Indicate # of checks performed 297)	3,113
Patient Background Checks	328 3,280
Dues & Subscriptions	7,002
Association Dues	11,342
Advertising	16,566
Other Licenses & Permits	799
Less Non-allowable Association Dues	(7,448)
Less: Public Relations Expense	()
Non-allowable advertising	(16,566)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	21,197
Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 21,197

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IHCA \$3894

(3)

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

Yes

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

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

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.

\$

58,088

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.

\$

61,320

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.

\$

253

(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.