

		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>0049403</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heartland of Moline IL, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>833 16th Avenue</u> <u>Moline</u> <u>61625</u>																									
Number City Zip Code																									
County: <u>Rock Island</u>																									
Telephone Number: <u>(309) 764-6744</u> Fax # <u>(309) 764-8176</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Barry A. Lazarus</u></td></tr><tr><td>(Title) <u>Vice President, Reimbursement</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>	(Title) <u>Vice President, Reimbursement</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>																								
	(Title) <u>Vice President, Reimbursement</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>1966</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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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Garv Geise</u> Telephone Number: <u>(419) 252-5731</u>																									
Email Address: _____																									

Facility Name & ID Number Heartland of Moline IL, LLC

0049403 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>149</u>	Skilled (SNF)	<u>149</u>	<u>54,385</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>149</u>	TOTALS	<u>149</u>	<u>54,385</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>2,783</u>	<u>22,859</u>	<u>22,999</u>	<u>48,641</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>2,783</u>	<u>22,859</u>	<u>22,999</u>	<u>48,641</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.44%

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

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

N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/83

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 118 and days of care provided 17,266

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Heartland of Moline IL, LLC # 0049403 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	300,783	23,644	80,474	404,901		404,901		404,901			1
2	Food Purchase		353,581		353,581		353,581	(782)	352,799			2
3	Housekeeping	205,596	16,610	757	222,963		222,963		222,963			3
4	Laundry	71,943	17,183	129	89,255		89,255		89,255			4
5	Heat and Other Utilities			192,437	192,437	2,551	194,988		194,988			5
6	Maintenance	48,343	7,694	56,862	112,899		112,899		112,899			6
7	Other (specify):* Medical Waste			1,020	1,020		1,020		1,020			7
8	TOTAL General Services	626,665	418,712	331,679	1,377,056	2,551	1,379,607	(782)	1,378,825			8
	B. Health Care and Programs											
9	Medical Director			(1,559)	(1,559)		(1,559)		(1,559)			9
10	Nursing and Medical Records	3,076,064	277,699	66,154	3,419,917	16,096	3,436,013		3,436,013			10
10a	Therapy	1,513,244	16,854	104,438	1,634,536		1,634,536		1,634,536			10a
11	Activities	135,205	5,738	3,757	144,700		144,700		144,700			11
12	Social Services	158,658	281	724	159,663		159,663		159,663			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,883,171	300,572	173,514	5,357,257	16,096	5,373,353		5,373,353			16
	C. General Administration											
17	Administrative	170,546		688,575	859,121	(315,329)	543,792		543,792			17
18	Directors Fees											18
19	Professional Services			8,084	8,084		8,084	(8,190)	(106)			19
20	Dues, Fees, Subscriptions & Promotions			84,467	84,467		84,467	(57,302)	27,165			20
21	Clerical & General Office Expenses	423,978	59,419	204,838	688,235		688,235	(217,036)	471,199			21
22	Employee Benefits & Payroll Taxes			1,079,108	1,079,108	34,409	1,113,517		1,113,517			22
23	Inservice Training & Education			6,449	6,449		6,449		6,449			23
24	Travel and Seminar			23,165	23,165		23,165		23,165			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			421,474	421,474		421,474		421,474			26
27	Other (specify):*											27
28	TOTAL General Administration	594,524	59,419	2,516,160	3,170,103	(280,920)	2,889,183	(282,528)	2,606,655			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,104,360	778,703	3,021,353	9,904,416	(262,273)	9,642,143	(283,310)	9,358,833			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			584,576	584,576	17,780	602,356		602,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,535,922	1,535,922	244,493	1,780,415	(1,537,654)	242,761			32
33	Real Estate Taxes			126,986	126,986		126,986		126,986			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68,768	68,768		68,768		68,768			35
36	Other (specify):*											36
37	TOTAL Ownership			2,316,252	2,316,252	262,273	2,578,525	(1,537,654)	1,040,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		565,465		565,465		565,465		565,465			39
40	Barber and Beauty Shops			13,818	13,818		13,818		13,818			40
41	Coffee and Gift Shops	157,191			157,191		157,191		157,191			41
42	Provider Participation Fee			81,578	81,578		81,578		81,578			42
43	Other (specify):* IV, xray & lab		71,247	85,500	156,747		156,747		156,747			43
44	TOTAL Special Cost Centers	157,191	636,712	180,896	974,799		974,799		974,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,261,551	1,415,415	5,518,501	13,195,467		13,195,467	(1,820,964)	11,374,503			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	(782)	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	(823)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(519)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(631)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,190)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,375)	21		24
25	Fund Raising, Advertising and Promotional	(57,302)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached pg 5A	(1,620,342)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,820,964)		\$	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))	\$ (1,820,964)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0049403

01/01/2011

12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Wages - Marketing	\$ (61,288)	21	1
2	Employee benefits - Marketing	(18,130)	21	2
3	HCP Lease Interest	(1,537,654)	32	3
4	Vending Income	(3,146)	21	4
5	Misc. Income	(124)	21	5
6	Acitivity Income		11	6
7	Loss on Disposal of Fixed Assets		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(1,620,342)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[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	\$ 688,575	HCR Manor Care Services, LLC	100.00%	\$ 688,575		1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,261,551	Heartland Employment Services, LLC	100.00%	6,261,551		4
5	V	10a	Therapy Management	17,745	Heartland Rehab Services, LLC	100.00%	17,745		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			\$ 6,967,871			\$ 6,967,871	\$ *	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 Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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25								25
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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 Moline IL, LLC # 0049403 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	731 NFs, HHs, & R	\$ 775,999	\$	12,376,465	\$ 2,551	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	353 NFs			12,376,465	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	92 NFs			12,376,465	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	48 NFs			12,376,465	0	4
5	10	Nursing - Pooled	Accumulated Cost	731 NFs, HHs, & Re	485,056	352,684	12,376,465	1,594	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	353 NFs	3,905,972	1,829,606	12,376,465	14,502	6
7	10	Nursing - Direct to Central Division	Accumulated Cost	92 NFs			12,376,465	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	48 NFs			12,376,465	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	731 NFs, HHs, & Re	71,430,003	38,287,220	12,376,465	234,793	9
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	353 NFs	23,601,055	18,695,747	12,376,465	87,625	10
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	92 NFs	1,782,698	1,278,408	12,376,465	27,464	11
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	48 NFs	895,017	639,204	12,376,465	23,364	12
13	22	Employee Benefits - Pooled	Accumulated Cost	731 NFs, HHs, & Re	2,952,374		12,376,465	9,705	13
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	353 NFs	6,653,909		12,376,465	24,704	14
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	92 NFs			12,376,465	0	15
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	48 NFs			12,376,465	0	16
17	30	Depreciation - Pooled	Accumulated Cost	731 NFs, HHs, & Re	4,719,938		12,376,465	15,515	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	353 NFs	609,966		12,376,465	2,265	18
19	30	Depreciation - Direct to Central Division	Accumulated Cost	92 NFs			12,376,465	0	19
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	48 NFs			12,376,465	0	20
21	32	Pooled Interest	Accumulated Cost		26,343,470		12,376,465	86,592	21
22	32	Directly Assigned Interest	Not Allocated		18,851,990			157,901	22
23		H/O Costs Allocated to Non-SNFs and Other Divisions			32,615,916				23
24									24
25	TOTALS				\$ 195,623,363	\$ 61,082,869		\$ 688,575	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Various			Purchased Facility		10/3/1991	\$ 389,893	\$ 389,893		0.0665	\$ 25,944	1	
2	Various			Finance Capital Additions		3/07 & 11/97	972,504	972,504		0.0665	64,713	2	
3	Various			Finance Capital Additions		6/01 & 9/01	1,010,547	1,010,547		0.0665	67,244	3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										86,592	7	
8	Interest Income Other										(1,732)	8	
9	TOTAL Facility Related						\$ 2,372,944	\$ 2,372,944			\$ 242,761	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,372,944	\$ 2,372,944			\$ 242,761	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.	\$120,548	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.)			\$123,767	2
3. Under or (over) accrual (line 2 minus line 1).			\$3,219	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$123,767	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.			\$126,986	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2006105,6468	FOR BHF USE ONLY	
		2007115,1159		
		2008119,28110	13FROM R. E. TAX STATEMENT FOR 2010\$13	
		2009120,54711	14PLUS APPEAL COST FROM LINE 5\$14	
		2010123,76712	15LESS REFUND FROM LINE 6\$15	
			16AMOUNT TO USE FOR RATE CALCULATION\$16	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Heartland of Moline IL, LLC</u>	COUNTY	<u>Rock Island</u>
FACILITY IDPH LICENSE NUMBER	<u>0049403</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Gary Geise</u>		
TELEPHONE	<u>(419) 252-5731</u>	FAX #:	<u>(419) 254-5495</u>

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:

50,742

B. General Construction Type:

ExteriorMasonry

FrameSteel, Fire Resistant

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983 & 2003	\$181,010	1
2			2006	48,251	2
3	TOTALS			\$229,261	3

Facility Name & ID Number Heartland of Moline IL, LLC

0049403

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118		1996	1996	\$ 1,033,964	\$ 89,989		\$ 89,989	\$	2,350,662	4
5				1993	56,519						5
6	11			1998	1,398,475						6
7	10 beds in 2001 & 10 beds in 2006			2001	821,410						7
8	Physical Therapy addition-general contractor			2010	267,733						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					318,211		318,211		3,267,079	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Moline IL, LLC

0049403

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

1	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 Land Improvements	1995	\$ 980	\$		\$	\$	\$	37
38 Building Improvements	1995	32,598						38
39 Land Improvements: Sign, Landscatping, and Concrete Bumpers	1996	25,027						39
40 Building Improvements: Painting/Wallcovering, Carpet, Paging system,	1996	126,134						40
41 doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								41
42 hand rails,electrical wiring, ceramic tile, and bathroom sinks								42
43 Building Improvements: Fire alarm	1996	45,151						43
44 Building Improvements: Intercom system	1996	27,230						44
45 Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414						45
46 architect and engineering fees, interior design costs, drywall and								46
47 corner guards, aluminum chips, electrical heating, air conditioning								47
48 fire stop installation and access doors, and storage fees								48
49 Building Improvements: Wallcovering	1996	118,024						49
50 Building Improvements: Sewer Runs	1997	10,708						50
51 Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						51
52 door frames, millwork, carpentry, caulking, ceilings plaster,								52
53 plumbing comosite, electrical composite, sinks, conduit wiring,								53
54 door closing devices, nurses call system								54
55 Building Improvements: 18 Bed Addition, wallcovering, conncrete,	1997	334,930						55
56 doors wood, telephone system, fencing wire, electrical transformer,								56
57 HVAC, hollow metal doors, duct work								57
58 Building Improvements: Install HVAC, electrical composite	1997	291,760						58
59 Building Improvements: Roof Replacement	1997	49,483						59
60 Building Improvements: Door	1997	1,042						60
61 Building Improvements: Siding on new additon	1997	4,993						61
62 Building Improvement: VWC from Inventory	1997	1,464						62
63 Land Improvements: Sign	1997	593						63
64 Land Improvements: Landscaping	1997	801						64
65 Land Improvements: Fence	1997	5,422						65
66 Bldg. Improvements: Cupola	1998	5,440						66
67 Bldg. Improvements: HVAC	1998	23,069						67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,522,732	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	70

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

Facility Name & ID Number Heartland of Moline IL, LLC

0049403

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,522,732	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	1
2	Bldg. Improvements: Roof	1998	8,203						2
3	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						3
4	Bldg. Improvements: Add't HVAC	1998	15,464						4
5	Bldg. Improvements: 8 Bed Addition	1998	88,423						5
6	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						6
7	Land Improvements: Grading	1998	1,779						7
8	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						8
9	Bldg. Improvements: Doors	1998	10,151						9
10	Asphalt Work	1999	14,164						10
11	Smoking Shelter	1999	5,254						11
12	Overhead from Const	1999	29,447						12
13	Concrete Pad for Smoking	1999	924						13
14	Exit Device	1999	474						14
15	Carpet	1999	994						15
16	Carpet	1999	553						16
17	Awning	1999	2,788						17
18	Building Decorations	1999	653						18
19	Retainage for Carpet	1999	73						19
20	Retainage Fee for Carpet	1999	59						20
21	Wallboard	1999	568						21
22	Wiring	1999	3,850						22
23	Wall, Drain Lines, Electrica	1999	15,776						23
24	Boiler Pump	2000	5,433						24
25	HVAC Upgrade	2000	1,600						25
26	Boiler room exhuast	2000	5,684						26
27	Phone line	2000	800						27
28	Phone line	2000	800						28
29	Ceramic tile	2000	511						29
30	Carpet	2000	842						30
31	Sinks & faucet	2000	1,055						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,809,233	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	34

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

Facility Name & ID Number Heartland of Moline IL, LLC

0049403

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,809,233	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	1
2	Add'l cost sinks	2000	218						2
3	Add'l cost carpeting	2000	59						3
4	Add'l cost carpet	2000	94						4
5	Retainer on boiler room exhaust	2000	632						5
6	Replace door in laundry	2000	4,932						6
7	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						7
8	Bldg Imprv - Carpentry/Electrical	2001	60,645						8
9	Bldg Imprv - Wallcovering	2001	11,630						9
10	Land Imprv - Concrete work	2001	4,941						10
11	Land Imprv - Walkway & Canopy	2001	3,858						11
12	Wire Component Connection	2001	2,543						12
13	Wire Component Connection	2002	327						13
14	Wire Component Connection	2002	402						14
15	Building Addition - VWC - Corridor	2002	19,847						15
16	Paint, VWC - Corridor Renovation	2001	45,377						16
17	Corner Guards	2002	7,153						17
18	Mini-Edger	2002	729						18
19	Corner Guards - Asset adjustment	2002	(4,953)						19
20	Building Addition - Paving/Landscaping	2002	8,679						20
21	Building Addition - Paving/Landscaping	2002	8,397						21
22	Building Addition - Paving/Landscaping	2002	111,907						22
23	Paving	2002	5,025						23
24	2 Dell celeron	2002	1,687						24
25	Electrical Work Overhead & Interest	2003	55,146						25
26	Overhead & Interest	2003	8,734						26
27	General Construction	2003	5,540						27
28	Carpet and Flooring	2003	83,248						28
29	Floorcovering	2003	702						29
30	Floorcovering	2003	251						30
31	HVAC	2003	7,643						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,276,159	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,276,159	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	1
2	HVAC Kitchen retainage	2003	5,627						2
3	Overhead & Interest	2003	8,231						3
4	Overhead & Interest	2003	(8,231)						4
5	Retro Cost Adjustment	2003	84,377						5
6	Retro Cost Adjustment	2003	48,938						6
7	Sealcoat & Restripe Pkg.	2004	(48,938)						7
8	Sealcoat & Restripe Pkg.	2004	2,602						8
9	VWC	2004	68						9
10	Flooring and Painting	2004	1,486						10
11	VWC & Painting	2004	1,278						11
12	Carpet	2004	472						12
13	Interest	2005	3,449						13
14	Interest	2005	(3,449)						14
15	General Overhead	2005	46,589						15
16	General Overhead	2005	(46,589)						16
17	Fire Sprinkler System	2005	142,143						17
18	EXHAUST SYSTEM	2005	7,150						18
19	condensing unit	2006	4,193						19
20	Addition - Soil Testing & Plan Reviews	2006	28,303						20
21	Addition - Site Clearing, Grading, Concrete, Treatment, & Prep	2006	25,048						21
22	Addition - Landscaping	2006	45,850						22
23	Addition - Asphalt Paving	2006	16,258						23
24	Addition - Concrete Paving & Cast Stone	2006	139,095						24
25	Addition - Sewar Replacement & Fees	2006	36,004						25
26	Addition - Permit Fees	2006	9,757						26
27	Addition - Pre Construction & Bldg. Excavation	2006	139,343						27
28	Addition - Site Utilities	2006	11,905						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,977,119	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,977,119	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	1
2	Addition - General Conditions	2006	115,912						2
3	Addition - Carpentry-Subcontr.	2006	195,647						3
4	Addition - Roofing/Waterproofing	2006	4,393						4
5	Addition - HM Doors/Frames/Drywall/Studs	2006	9,905						5
6	Addition - Wood Doors	2006	24,735						6
7	Addition - Ceiling Tile & Flooring	2006	17,927						7
8	Addition - Carpet/Paint/WC/Corner Guards	2006	42,687						8
9	Addition - Fire Sprinkler Syster	2006	19,963						9
10	Addition - Plumbing	2006	59,204						10
11	Addition - Basic Electrical	2006	108,830						11
12	Addition - Archetectual & Engineering Cost	2006	128,176						12
13	Addition - General Overhead	2006	71,933						13
14	Addition - Builders Risk Insurance	2006	1,100						14
15	Addition - Gypsum Board System	2006	62,975						15
16	Addition - Masonry & Metals	2006	142,412						16
17	Addition - Demolition	2006	13,731						17
18	Renov - General Overhead	2007	13,148						18
19	Renov - Carpentry - Subcontractor	2007	46,583						19
20	Renov - Wallcovering	2007	106,341						20
21	Renov - Interest on Construction	2007	957						21
22	0807 STORMSEWERS COURTYRD	2008	3,309						22
23	Adj 2006 Asset Addition - Arch & Engineering Cost	2008	1,765						23
24	Adj 2006 Asset Addition - General Overhead	2008	150						24
25	Adj 2006 Asset Addition - Arch & Engineering Cost	2008	1,943						25
26	0807 STORMSEWERS COURTYRD	2008	67,397						26
27	CONCRETE SIDEWALK	2008	1,672						27
28									28
29	Alum siding	2008	4,500						29
30	Door entrance closers	2008	3,613						30
31	alum siding	2009	2,223						31
32	000000090694 Safety ren-ovhead	2009	3,035						32
33	000000090694 Safety ren-interest	2009	167						33
34	TOTAL (lines 1 thru 33)		\$ 8,253,451	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	34

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

Facility Name & ID Number Heartland of Moline IL, LLC

0049403

Report Period Beginning:

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

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

1	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		\$ 8,253,451	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	1
2 000000090695 Safey ren-carpentry	2009	13,140						2
3 000000090695 Safey ren-hm doors & frames	2009	17,553						3
4 000000090695 Safey ren-sprinklers	2009	1,228						4
5 000000090699 Cor ren-Gen ovhd capit	2009	6,495						5
6 000000090699 Cor ren-interest on const	2009	378						6
7 000000090699 Cor ren-resilient flooring	2009	95,159						7
8 000000090699 Cor ren-carpeting & pads	2009	1,342						8
9 000000090699 Cor ren-wall covering	2009	11,954						9
10 000000090699 Cor ren-cornder guards	2009	103						10
11 000000090699 Cor ren-resilient flooring	2009	123,012						11
12 000000090699 Cor ren-carpeting & pads	2009	1,162						12
13 000000090699 Cor ren-wall covering	2009	8,830						13
14 000000090704 Hollow metal door	2009	2,445						14
15 000000090705 ADJ ASSET #90699	2009	2,803						15
16 000000090706 ADJ ASSET #90699	2009	448						16
17 000000090708 vwc and ceiling tiles in	2009	13,241						17
18 000000090692 CONCRETE SIDEWALK	2008	21,279						18
19 000000090697 Grading and sub-drain til	2009	21,391						19
20								20
21 BI 090713 ADJ ASSET 90699-vwc & ceiling tiles	2010	13,241						21
22 BI 090716 MOLINE PT-Arch & Eng costs	2010	84,024						22
23 BI 090717 CLSE PROJ MLNE PT MOVE-gen o/h cap	2010	17,706						23
24 BI 090721 MOLINE PT-wall covering	2010	1,310						24
25 BI 090733 ADJ ASSET #90721-wall covering	2010	2,026						25
26 BI 090738 Vestibule, front entry, seating renovation	2010	8,037						26
27 BI 090743 adj asset 90738-vestibule renovation	2010	8,037						27
28 LI 090722 MOLINE PT-general contractor	2010	157,687						28
29 LI 090723 MOLINE PT-soil & concrete testing	2010	7,645						29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 8,895,127	\$ 408,200		\$ 408,200	\$	\$ 5,617,741	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	\$2,711,866	\$176,376	\$176,376	\$		\$2,227,036	71
72	Current Year Purchases	126,489						72
73	Fully Depreciated Assets							73
74	Home Offcie			17,780	17,780			74
75	TOTALS	\$2,838,355	\$176,376	\$194,156	\$17,780		\$2,227,036	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	Transport residents	1986 Chevy van with chair lift		\$22,049	\$	\$	\$		\$22,049	76
77										77
78										78
79										79
80	TOTALS			\$22,049	\$	\$	\$		\$22,049	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)	\$11,984,792	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$584,576	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$602,356	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$17,780	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,866,826	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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$40,314
- Description:02 Concentrators, wheelchairs, gerichairs, electric beds, etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient transportation	1995 & 2009 Ford Bus	\$	\$28,454	17
18				above figure includes	18
19				gas & maintenance too.	19
20					20
21	TOTAL		\$	\$28,454	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

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

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

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

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

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

	1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	9469	hrs	\$ 381,304	541	\$ 29,551	\$ 817	10,010	\$ 411,672	1
2	Licensed Speech and Language Development Therapist	10a	3071	hrs	123,681			611	3,071	124,292	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	8960	hrs	360,832	167	9,125	15,426	9,127	385,383	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				565,465		565,465	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						71,247		71,247	12
13	Other (specify): <u>Xray & laboratory</u>	43, 3					85,500			85,500	13
14	TOTAL				\$ 865,817	708	\$ 124,176	\$ 653,566	22,208	\$ 1,643,559	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	\$ 4,963	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 323,418)	1,319,358		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,324,321	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,261		13
14	Buildings, at Historical Cost	8,895,125		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,860,404		16
17	Accumulated Depreciation (book methods)	(7,866,826)		17
18	Deferred Charges	38,928,889		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)	\$ 43,046,853	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 44,371,174	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 149,447	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	479,721		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,767		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	66,026		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 818,961	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,432,324		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 41,432,324	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 42,251,285	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,119,889	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 44,371,174	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,762,589	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,762,589	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,392,680	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)	\$ 3,392,680	17
	B. Transfers (Itemize):		
18	Change in interdivision	(6,035,380)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (6,035,380)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,119,889	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Heartland of Moline IL, LLC**# **0049403**Report Period Beginning: **01/01/2011**Ending: **12/31/2011**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,479,636	1
2	Discounts and Allowances for all Levels	(4,651,190)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,828,446	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,925,707	6
7	Oxygen	7,124	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,932,831	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	3,665	12
13	Barber and Beauty Care	13,432	13
14	Non-Patient Meals	782	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	592,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,971	19
20	Radiology and X-Ray	52,423	20
21	Other Medical Services	96,229	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 826,115	23
	D. Non-Operating Revenue		
24	Contributions	631	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 631	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	124	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,588,147	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,377,056	31
32	Health Care	5,357,257	32
33	General Administration	3,170,103	33
	B. Capital Expense		
34	Ownership	2,316,252	34
	C. Ancillary Expense		
35	Special Cost Centers	893,221	35
36	Provider Participation Fee	81,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,195,467	40
41	Income before Income Taxes (line 30 minus line 40)**	3,392,680	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,392,680	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	2,025	2,232	\$ 89,090	\$ 39.91	1
2	Assistant Director of Nursing	3,416	3,764	113,057	30.04	2
3	Registered Nurses	18,360	20,233	521,643	25.78	3
4	Licensed Practical Nurses	40,315	44,427	831,612	18.72	4
5	CNAs & Orderlies	107,841	119,088	1,424,306	11.96	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	21,499	23,684	953,818	40.27	7
8	Rehab/Therapy Aides	20,378	22,449	559,426	24.92	8
9	Activity Director	10,250	11,315	135,205	11.95	9
10	Activity Assistants					10
11	Social Service Workers	7,572	8,357	158,658	18.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,347	27,970	300,783	10.75	15
16	Dishwashers					16
17	Maintenance Workers	1,890	2,084	48,343	23.20	17
18	Housekeepers	16,943	18,708	205,596	10.99	18
19	Laundry	5,611	6,198	71,943	11.61	19
20	Administrator	2,080	2,080	109,258	52.53	20
21	Assistant Administrator	1,992	1,992	61,288	30.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,681	20,487	439,023	21.43	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	3,925	4,329	81,311	18.78	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	10,245	11,303	157,191	13.91	33
34	TOTAL (lines 1 - 33)	317,370	350,700	\$ 6,261,551 *	\$ 17.85	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	(1,559)	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ (1,559)		49

C. CONTRACT NURSES

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

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Yes

If YES, give association name and amount.

IHCA \$5051
- (3)

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

Yes \$6843

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.

\$ 85,646

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.

\$ 81,578

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.

\$ 782
- (16)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

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

No

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

\$
- (17)

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

No

Firm Name:
- (18)

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

Yes
- (19)

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

No

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