

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0049296</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Heartland of Canton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>2081 N. Main Street</u> <u>Canton</u> <u>61520</u>																																																	
Number City Zip Code																																																	
County: <u>Fulton</u>																																																	
Telephone Number: <u>(309) 647-6135</u> Fax # <u>(309) 647-6141</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><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 rowspan="5">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Barry A. Lazarus</u>	(Title) <u>Vice President, Reimbursement</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>	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																																			
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	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																																																
Date of Initial License for Current Owners: <u>09/09/1988</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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:																																																	
Name: <u>Garv Geise</u> Telephone Number: <u>419-252-5731</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Heartland of Canton# 0049296 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,940</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>11,130</u>	<u>8,141</u>	<u>7,594</u>	<u>26,865</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>11,130</u>	<u>8,141</u>	<u>7,594</u>	<u>26,865</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.56%

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)

None

F. Does the facility maintain a daily midnight census?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/26/1988

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/07/2011NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 90 and days of care provided 3,687Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31Fiscal Year: 12/31

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

	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	223,571	16,880	13,087	253,538		253,538		253,538			1
2	Food Purchase		177,743		177,743		177,743	(7,686)	170,057			2
3	Housekeeping	98,866	12,392	4,258	115,516		115,516		115,516			3
4	Laundry	38,701	13,955	(537)	52,119		52,119		52,119			4
5	Heat and Other Utilities			147,354	147,354	1,260	148,614		148,614			5
6	Maintenance	47,077	10,685	117,700	175,462		175,462		175,462			6
7	Other (specify):* Medical Waste			451	451		451		451			7
8	TOTAL General Services	408,215	231,655	282,313	922,183	1,260	923,443	(7,686)	915,757			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,686,535	143,845	45,686	1,876,066	7,849	1,883,915		1,883,915			10
10a	Therapy	488,608	7,712	59,026	555,346		555,346		555,346			10a
11	Activities	47,707	2,783	1,893	52,383		52,383	(330)	52,053			11
12	Social Services	82,508	14	3,415	85,937		85,937		85,937			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,305,358	154,354	125,020	2,584,732	7,849	2,592,581	(330)	2,592,251			16
	C. General Administration											
17	Administrative	76,506		261,651	338,157	(91,213)	246,944		246,944			17
18	Directors Fees											18
19	Professional Services			33,657	33,657		33,657	(33,522)	135			19
20	Dues, Fees, Subscriptions & Promotions			81,420	81,420		81,420	(55,316)	26,104			20
21	Clerical & General Office Expenses	247,819	42,885	196,612	487,316		487,316	(161,026)	326,290			21
22	Employee Benefits & Payroll Taxes			585,984	585,984	24,311	610,295		610,295			22
23	Inservice Training & Education			6,011	6,011		6,011		6,011			23
24	Travel and Seminar			20,583	20,583		20,583		20,583			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			493,027	493,027		493,027		493,027			26
27	Other (specify):*											27
28	TOTAL General Administration	324,325	42,885	1,678,945	2,046,155	(66,902)	1,979,253	(249,864)	1,729,389			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,037,898	428,894	2,086,278	5,553,070	(57,793)	5,495,277	(257,880)	5,237,397			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			333,815	333,815	8,929	342,744		342,744			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			427,181	427,181	48,864	476,045	(427,907)	48,138			32
33	Real Estate Taxes			134,422	134,422		134,422		134,422			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,233	33,233		33,233		33,233			35
36	Other (specify):*											36
37	TOTAL Ownership			928,651	928,651	57,793	986,444	(427,907)	558,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,317	3,317		3,317		3,317			38
39	Ancillary Service Centers		114,642		114,642		114,642		114,642			39
40	Barber and Beauty Shops			8,868	8,868		8,868		8,868			40
41	Coffee and Gift Shops	20,704			20,704		20,704		20,704			41
42	Provider Participation Fee			296,694	296,694		296,694		296,694			42
43	Other (specify):* IV, X-ray& Lab		39,553	29,901	69,454		69,454		69,454			43
44	TOTAL Special Cost Centers	20,704	154,195	338,780	513,679		513,679		513,679			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,058,602	583,089	3,353,709	6,995,400		6,995,400	(685,787)	6,309,613			45

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

	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	(7,686)	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	(267)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,000)	21		18
19	Entertainment				19
20	Contributions	(525)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(33,522)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(147,772)	21		24
25	Fund Raising, Advertising and Promotional	(55,316)	20		25
	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	(428,699)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (685,787)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (685,787)		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

Heartland of Canton

Report Period Beginning:

Ending:

ID#0049296

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Wages - Marketing	\$	21	1
2	P/R O/H Alloc- Mktg		21	2
3	HCP Lease Interest	(427,907)	32	3
4	Vending Income	(462)	21	4
5	Misc Income		21	5
6	Activity Income	(330)	11	6
7	Loss on disposal of Fixed Asset		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(428,699)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Canton # 0049296 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,686)	0	0	0	0	0	0	0	0	0	0	(7,686)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,686)	0	0	0	0	0	0	0	0	0	0	(7,686)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(330)	0	0	0	0	0	0	0	0	0	0	(330)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(330)	0	0	0	0	0	0	0	0	0	0	(330)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,522)	0	0	0	0	0	0	0	0	0	0	(33,522)	19
20	Fees, Subscriptions & Promotions	(55,316)	0	0	0	0	0	0	0	0	0	0	(55,316)	20
21	Clerical & General Office Expenses	(161,026)	0	0	0	0	0	0	0	0	0	0	(161,026)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(249,864)	0	0	0	0	0	0	0	0	0	0	(249,864)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(257,880)	0	0	0	0	0	0	0	0	0	0	(257,880)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(427,907)	0	0	0	0	0	0	0	0	0	0	(427,907)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(427,907)	0	0	0	0	0	0	0	0	0	0	(427,907)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(685,787)	0	0	0	0	0	0	0	0	0	0	(685,787)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	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 Heath Care	Toledo	Nursing Staff
		See Pg 6 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	\$ 261,651	HCR Manor Care Services, LLC	100.00%	\$ 261,651	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,058,602	Heartland Employment Services, LLC	100.00%	3,058,602		4
5	V	10a	Therapy Management	10,633	Heartland Rehab Services, LLC	100.00%	10,633		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			\$ 3,330,886			\$ 3,330,886	\$ *	14

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

Facility Name & ID Number

Heartland of Canton

0049296

Report Period Beginning:

01/01/12

Ending:

12/31/12

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								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 Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Manor Care of Wilmette IL, LLC	Wilmette				29
30			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Canton # 0049296 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	\$ 748,673	\$ 0	6,728,937	\$ 1,260	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs		0	6,728,937	0	2
3	5	Utilities - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs		0	6,728,937	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	419,407	305,829	6,728,937	706	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	6,728,937	7,143	5
6	10	Nursing - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs			6,728,937	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	66,682,648	33,182,703	6,728,937	112,189	7
8	17	General & Administrative - Direct	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	6,728,937	34,390	8
9	17	General & Administrative - Direct	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,308	6,728,937	23,859	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	7,480,805	0	6,728,937	12,586	10
11	22	Employee Benefits - Direct to All	Accumulated Cost	3,550,656,576	354 NFs	6,187,019	0	6,728,937	11,725	11
12	22	Employee Benefits - Direct to Mid	Accumulated Cost	517,936,312	48 NFs		0	6,728,937	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	4,579,765	0	6,728,937	7,705	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474	0	6,728,937	1,224	14
15	30	Depreciation - Direct to Midwest	Accumulated Cost	517,936,312	48 NFs		0	6,728,937	0	15
16										16
17										17
18	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		6,728,937	43,527	18
19	32	Directly Assigned Interest	Not Allocated			18,513,013			5,337	19
20										20
21		H/O Costs Allocated to Non-SNFs and Other Divisions				30,612,518				21
22										22
23										23
24										24
25	TOTALS					\$ 185,493,069	\$ 50,996,411		\$ 261,651	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Various		X	Facility			\$ 81,675	\$ 81,675		0.0653	\$ 5,337	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										43,527	7	
8	Interest Income Other										(726)	8	
9	TOTAL Facility Related						\$ 81,675	\$ 81,675			\$ 48,138	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 81,675	\$ 81,675			\$ 48,138	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	72,220	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.)			\$	103,321	2
3. Under or (over) accrual (line 2 minus line 1).			\$	31,101	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	103,321	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.			\$	134,422	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 59,581 8			
		2008 66,134 9			
		2009 66,134 10			
		2010 72,220 11			
		2011 103,321 12			
			FOR BHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2011 \$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Heartland of Canton

COUNTY
Fulton

FACILITY IDPH LICENSE NUMBER
0049296

CONTACT PERSON REGARDING THIS REPORT
Gary Geise

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

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 09-08-15-205-007	See Attached	\$ 103,320.76	\$ 103,320.76
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 103,320.76	\$ 103,320.76

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:28,361

B. General Construction Type:ExteriorBrickFrameWood

Number of Stories1

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).

N/A

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	90		1988	1988	\$ 1,936,360	\$ 77,861		\$ 77,861		\$ 1,673,782
5	Audit adj 7/1/03 (#1)			1988	(1,508)					
6				1994	8,975					
7				2006	364,683					
8				2008	248,896					
	Improvement Type**									
9	Land Improvements (Current Year Depreciation)					156,132		156,132		1,651,419
10	Site Work			1988	125,431					
11	Sewer & Water Lines			1988	85,093					
12	Paving			1988	82,940					
13	Yew Trees			1991	4,440					
14	Landscaping - Stone Wall			1992	3,812					
15	Drain Tiles and Catch Basins			1992	7,550					
16	AUDIT ADJ 7/1/03 (#2) - Drain Tiles			1992	(45)					
17	AUDIT ADJ 7/1/03 (#2) -Reverse Adjustment			1992	45					
18	Credit on Land Imp-CNCLD Retainer			1992	(755)					
19	Fire Rated Door - Staff Development			1992	2,444					
20	Plumbing - Mixing Valve			1992	676					
21	Carpeting			1992	5,804					
22	AUDIT ADJ 7/1/03 (#3) - Carpeting			1992	(5,804)					
23	Carpet Vestibule Lounge - AUDIT ADJ 7/1/03 (#4) - CHG YEAR			1992	5,804					
24	Renovation (Moved from CIP in 1995)			1993	5,360					
25	Electrical (Moved from CIP in 1995)			1993	1,748					
26	Aluminum Awning			1993	1,376					
27	Wood Fence for Courtyard			1993	1,785					
28	Replace Sod			1993	2,575					
29	Seal & Stripe Parking Lot			1994	7,564					
30	Painting			1994	994					
31	Interior DR Remodel, Carpentry			1994	8,650					
32	Elec, Plumb, DR Remodel			1994	5,130					
33	Sprinkler Sys			1994	1,193					
34	Carpet Lobby, Offices, Nurses Station			1994	13,908					
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Sidewalk	1995	\$ 4,440	\$		\$	\$	\$	37
38	Fencing	1995	1,732						38
39	Vinyl Flooring	1995	949						39
40	Electrical	1995	1,154						40
41	Cabinets in Alzheimers Unit	1995	1,394						41
42	Counter Top	1995	244						42
43	Doors	1995	7,346						43
44	Architectural Fees A/L Lounge Renovation	1995	2,231						44
45	Electrical Engineering and Architectural Service Fees-CHG YR	1995	9,766						45
46	Carpet	1996	181						46
47	Painting	1996	1,750						47
48	Painting	1996	1,806						48
49	Labor, Material, Permits to Renovate A/L Lounge	1996	5,615						49
50	Carpeting	1996	1,060						50
51	(51) Doors	1996	8,278						51
52	Grilles for Sliding Glass Door for A/L Lounge	1996	181						52
53	Credit on BLD IMP- CNCLD Retainer	1996	(18)						53
54	Ceramic Tile	1996	3,511						54
55	Painting	1997	148						55
56	Architectural Services	1997	375						56
57	Architectural Services -Alzheimers Unit	1997	2,075						57
58	Additional Architectural Services	1997	500						58
59	Architectural Services - Alzheimers Unit	1997	575						59
60	Add'l't HVAC Cost	1997	232						60
61	Architectural Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	3,725						61
62	Engineering Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	250						62
63	Construction Overhead and Interest-AUDIT ADJ 7/1/03 (#7) CHG	1997	18,034						63
64	HVAC - AUDIT AJD 7/1/03 (#7) CHG YEAR	1997	194,747						64
65	Lift Station - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	25,000						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,222,406	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	70

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

Facility Name & ID Number Heartland of Canton

0049296

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12A, Carried Forward		\$ 3,222,406	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	HVAC	1998	35,458						2
3	A/C DESIGN & INSTALLATION	1998	36,185						3
4	AA ON ROOFTOP UNIT	1998	7,360						4
5	ROOF TOP UNIT	1998	11,100						5
6	FACIA BOARD & GUTTERS	1998	13,000						6
7	Asphalt Paving	1998	17,441						7
8	INSTALL HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,475						8
9	INSTALL DAMPER HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	643						9
10	INSTALL RTU HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,200						10
11	WALLCOVERINGS	1999	5,319						11
12	CONSTRUCTION OVERHEAD	1999	11,221						12
13	AUDIT ADJ 7/1/03 (#8) - OVERHEAD	1999	(11,221)						13
14	WALLCOVERINGS	1999	4,097						14
15	AUDIT ADJ 7/1/03 (#9) - WALLCOVERINGS	1999	(225)						15
16	SECURE CARE LOCKING SYSTEM	1999	5,101						16
17	PARTITIONS	1999	738						17
18	WALLCOVERINGS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,233						18
19	CORNER GUARDS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	251						19
20	COVE BASE-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	539						20
21	LOREN COOK ROOF EXHAUST-AUDIT ADJ 7/1/03 (#10) CHG	1999	1,325						21
22	WALL VINYL COVERING	1999	1,936						22
23	CABINETS & TOPS	1999	5,247						23
24	PAINTING	1999	1,450						24
25	PAINTING	1999	17,000						25
26	AUDIT ADJ 7/1/03 (#11) - PAINTING	1999	(17,000)						26
27	FLOORING - COVE BASE	1999	1,258						27
28	CUSTOM CABINETS	1999	5,820						28
29	PAINTING	1999	15,000						29
30	CEILING INSTALLATION-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1999	10,367						30
31	AUDIT ADJ 7/1/03 (#13) - CEILING INSULATION	1999	(10,367)						31
32	DESIGN FEES FOR ALZHEIMERS UNIT	1999	1,050						32
33	DESIGN FEES FOR ALZHEIMERS UNIT	1999	(1,050)						33
34	TOTAL (lines 1 thru 33)		\$ 3,395,358	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	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		\$ 3,395,358	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	WALLCOVERING	1999	132						2
3	WALLCOVERING	1999	116						3
4	WALLCOVERING	1999	496						4
5	COOLER	1999	1,245						5
6	AUDIT ADJ 7/1/03 (#14) - COOLER	1999	(1,245)						6
7	WALLCOVERING	1999	744						7
8	AUDIT ADJ 7/1/03 (#15) - WALLCOVERING	1999	(744)						8
9	PAINTING	1999	33,450						9
10	AUDIT ADJ 7/1/03 (#16) - PAINTING	1999	(33,450)						10
11	CABINETRY & COUNTERTOPS	1999	11,067						11
12	AUDIT ADJ 7/1/03 (#17) - CABINETRY	1999	(11,067)						12
13	CARPETING & FLOORING	1999	1,258						13
14	AUDIT ADJ 7/1/03 (#18) - CARPETING	1999	(1,258)						14
15	HVAC	1999	3,318						15
16	AUDIT ADJ 7/1/03 (#19) - HVAC	1999	(3,318)						16
17	CEILING INSTALLATION	1999	10,367						17
18	AUDIT ADJ 7/1/03 (#20) - CEILING INSTALLATION	1999	(10,367)						18
19									19
20	FLOORING	2000	24,374						20
21	CONSTRUCTION OVERHEAD AND INTEREST	2000	31,653						21
22	AUDIT ADJ 7/1/03 (#21) - CONSTRUCTION	2000	(31,653)						22
23	DOOR HOLDERS	2000	1,623						23
24	FLOOR COVERING	2000	1,495						24
25	DRY SPRINKLER SYSTEM	2000	1,381						25
26	DRYWALL	2000	6,160						26
27	FREIGHT ON FABRIC	2001	534						27
28	FURNISH & INSTALL HANDRAILS	2001	943						28
29	DOORS	2001	4,200						29
30	ROOF	2001	13,000						30
31	COVE BASE	2001	5,885						31
32	AUDIT ADJ 7/1/03 (# 26) - COVE BASE	2001	(5,885)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,449,813	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	34

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

Facility Name & ID Number Heartland of Canton

0049296

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12C, Carried Forward		\$ 3,449,813	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	RESIDENT ROOM PAINTING	2002	4,484						2
3	AUDIT ADJ 7/1/03 (# 27) - RESIDENT ROOM PAINTING	2002	(4,484)						3
4	RESIDENT ROOM PAINTING	2002	38,492						4
5	AUDIT ADJ 7/1/03 (#22) - PAINTING	2002	(2,814)						5
6	DOORS	2002	3,225						6
7	GENERAL CONSTRUCTION	2002	9,542						7
8	RENOVATION ELECTRICAL-AUDIT ADJ 7/1/03 (#24) CHG YI	2002	61,600						8
9	AUDIT ADJ 7/1/03 (#23) - RENOVATION ELECTRICAL	2002	(2,284)						9
10	STAINLESS STEEL VWC	2002	9,059						10
11	STAINLESS STEEL VWC	2002	1,007						11
12	ROOF	2003	17,781						12
13	ROOF	2003	970						13
14	7/1/06 CAPITAL RATE ADJUST #1	2003	(970)						14
15	ROOFING & SHEET METAL	2003	53,562						15
16	GENERAL CONSTRUCTION	2003	3,994						16
17	AUDIT ADJ 7/1/03 (#25) - GENERAL CONSTRUCTION	2003	(3,994)						17
18	CARPET AND INSTALL	2003	22,469						18
19	PAVING	2003	72,546						19
20	OVERHEAD & INTEREST	2003	8,586						20
21	AUDIT ADJ 12/03 (#1) OVERHEAD & INT	2003	(8,586)						21
22	AUDIT ADJ 7/1/03 (#5) - PG 12A LINE 47 + PG 12A LINE 55	2003	(2)						22
23	AUDIT ADJ 7/1/03 (#5) - REVERSAL	2003	2						23
24	CEILING	2004	1,817						24
25	WINDOW	2004	3,078						25
26	DOOR	2004	1,600						26
27	SHEET VINYL FLOORING	2004	7,250						27
28	CUSTOM CABINETS	2004	2,354						28
29	VCT AND COVE BASE	2004	2,250						29
30	ARCH & ENGINEERING COSTS	2005	2,420						30
31	ARCH & ENGINEERING COSTS	2005	423						31
32	HANDRAIL AND BACKER	2005	27,820						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,783,011	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	34

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

Facility Name & ID Number Heartland of Canton

0049296

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12D, Carried Forward		\$ 3,783,011	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	<u>MAGNETIC DOOR</u>	2005	2,515						2
3	<u>METAL DOORS</u>	2005	2,485						3
4	<u>DOOR FRAMES</u>	2005	24,900						4
5	<u>ARCHITECT & ENGINEERING COSTS</u>	2005	10,281						5
6	<u>OVERHEAD & INTEREST</u>	2005	10,238						6
7	<u>7/1/06 CAPITAL RATE ADJUST #2</u>	2005	(10,238)						7
8	<u>INTEREST ON CONSTRUCTION</u>	2005	735						8
9	<u>7/1/06 CAPITAL RATE ADJUST #3</u>	2005	(735)						9
10	<u>WALLCOVERING</u>	2005	1,452						10
11	<u>7/1/06 CAPITAL RATE ADJUST #4</u>	2005	(1,452)						11
12	<u>PLAN REVIEWS</u>	2005	2,400						12
13	<u>BASIC ELECTRICAL</u>	2005	71,574						13
14	<u>INSTALLATION OF 10 PTAC UNITS</u>	2005	616						14
15	<u>GENERATOR</u>	2006	7,415						15
16	<u>GENERATOR</u>	2006	5,493						16
17	<u>INSTALLATION OF 5 PTAC UNITS</u>	2006	3,275						17
18	<u>ARCHITECT & ENGINEERING COSTS</u>	2006	36,887						18
19	<u>ARCHITECT & ENGINEERING COSTS</u>	2006	6,472						19
20	<u>ENGINEERING - CIVIL</u>	2006	8,600						20
21	<u>GENERAL OVERHEAD</u>	2006	20,273						21
22	<u>PLAN REVIEWS</u>	2006	7,286						22
23	<u>INTEREST ON CONSTRUCTION</u>	2006	3,433						23
24	<u>CARPETING & PADS</u>	2006	1,615						24
25	<u>WALLCOVERING</u>	2006	1,845						25
26	<u>SPRINKLERS</u>	2006	1,075						26
27	<u>HVAC</u>	2006	3,417						27
28	<u>VINYL WALL COVERING</u>	2006	1,022						28
29	<u>VINYL WALL COVERING</u>	2006	130						29
30	<u>CARPET</u>	2006	1,085						30
31	<u>CARPENTRY</u>	2006	15,800						31
32	<u>GENERAL CONTRACTOR - PT ADDITION</u>	2006	98,220						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,121,122	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	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 12E, Carried Forward		\$ 4,121,122	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	SOIL TESTING	2006	4,866						2
3	CONCRETE TESTING	2006	188						3
4	CONCRETE PAD AND RAMP	2007	13,712						4
5	1006 NURSE CALL SYSTEM	2007	8,691						5
6	1006 NURSE CALL SYSTEM	2007	1,133						6
7	window glass	2007	1,089						7
8	RETAINAGE FOR WIRING	2007	1,164						8
9	WIRING	2007	10,476						9
10	FIRE ALARM MOTHERBOARD	2007	1,620						10
11	CARPENTRY	2007	23,900						11
12	SIDEWALK	2007	23,500						12
13	SIDEWALK	2007	3,750						13
14	SIDEWALK INSTALLATION	2008	3,980						14
15	SIDEWALK	2008	1,070						15
16	ENG COSTS FOR SIDEWALK DESIGN	2007	5,447						16
17	CARPET - PT ADDITION	2008	3,337						17
18	CANTON PT ADT'N-GEN'L CNTR SITE WORK	2008	9,654						18
19	CANTON PT ADT'N-ARCH & ENGR COSTS	2008	55,263						19
20	CANTON PT ADT'N-GEN'L O-H CAPITAL	2008	83,955						20
21	CANTON PT ADT'N-PLAN REVIEWS	2008	6,000						21
22	CANTON PT ADT'N-INT ON COSTS	2008	12,978						22
23	CANTON PT ADT'N-MILLWORK	2008	131						23
24	CANTON PT ADT'N-RESILIENT FLOORING	2008	2,940						24
25	CANTON PT ADT'N-CARPETING & PADS	2008	3,347						25
26	CANTON PT ADT'N-WALL COVERING	2008	4,099						26
27	CANTON PT ADT'N-CORNER GUARDS	2008	195						27
28	DOOR OPENERS	2008	6,085						28
29	garage electrical	2008	318						29
30	garage electrical	2008	2,862						30
31	SPRINKLER PIPING	2008	20,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,436,871	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	34

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

Facility Name & ID Number Heartland of Canton

0049296

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12F, Carried Forward		\$ 4,436,871	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	1
2	Parking Blocks	2009	7,200						2
3	FIRE ALARM MOTHERBOARD	2007	(1,620)						3
4	paint 32 rooms	2008	3,350						4
5	adj asset 20422	2007	(1,620)						5
6	sprinkler system	2009	25,430						6
7	sprinkler system	2009	151						7
8	drainage piping	2009	76,290						8
9	LI 020496 courtyard lights	2010	3,225						9
10	LI 020497 sidewalk	2010	7,445						10
11	LI 020498 add'l cost sidewalk	2010	7,445						11
12									12
13	BI 020502 double egress doors	2010	13,510						13
14	BI 020509 Install radiant heat in halls, dining room, lobby, kitchen	2011	35,202						14
15	BI 020510 install radiant heat in halls, dining room, lobby, kitchen	2011	3,612						15
16	BI 020522 remove walls, patch, paint, primer walls	2011	36,927						16
17	BI 020524 WATER HEATER	2010	9,250						17
18	BI 020529 CABINTRY FOR CHARTING	2011	2,982						18
19	BI 020532 remove walls, patch, paint, primer walls	2011	3,285						19
20	BI 020533 double egress doors	2011	3,104						20
21	BI 020535 ADJUST ASSET # 20509	2011	2,950						21
22	BI 020537 WATER HEATER	2011	5,604						22
23	LI 020501 concrete sidewalk	2010	4,325						23
24	LI 020506 sealcoat pkg lot	2010	9,797						24
25	000000020546 0112 Exhaust System Upgrade	2012	33,736						25
26	000000020547 0112 Exhaust System Upgrade	2012	3,785						26
27	000000020552 0412 Mixing Valves	2012	45,741						27
28	000000020555 3 COMPARTMENT SINK	2012	3,942						28
29	000000020556 COOLING UNIT	2012	17,250						29
30	000000020557 ADJ ASSET #20552-mixing valves	2012	8,038						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,807,206	\$ 233,993		\$ 233,993	\$	\$ 3,325,201	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	\$1,707,485	\$99,822	\$99,822	\$		\$1,444,823	71
72	Current Year Purchases	42,800						72
73	Fully Depreciated Assets							73
74	Home Office			8,929	8,929			74
75	TOTALS	\$1,750,285	\$99,822	\$108,751	\$8,929		\$1,444,823	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,615,617	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$333,815	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$342,744	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,929	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,770,024	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

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. /2013 \$
13. /2014 \$
14. /2015 \$

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: \$ 20,149 Description: 02 Concentrators, wheelchairs, gerichairs, electric beds
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	2006 Ford E350 Van	\$	\$ 13,084	17
18					18
19				above figures includes	19
20				gas & maintenance too.	20
21	TOTAL		\$	\$ 13,084	21

* 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

ALLOCATION OF COSTS (d)

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

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

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.)

12345678											
	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	1047	hrs	\$ 43,701	345	\$ 24,000	\$ 320	1,392	\$ 68,021	1
2	Licensed Speech and Language Development Therapist	10a	2831	hrs	118,131	80	5,590	203	2,911	123,924	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2777	hrs	115,874	129	9,000	7,189	2,906	132,063	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				114,642		114,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						39,553		39,553	12
13	Other (specify): X-ray & Lab	43, 3					29,901			29,901	13
14	TOTAL				\$ 277,706	554	\$ 68,491	\$ 161,907	7,209	\$ 508,104	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	\$ 445	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 262,628)	960,000		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)	\$ 960,445	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,126		13
14	Buildings, at Historical Cost	4,807,204		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,750,286		16
17	Accumulated Depreciation (book methods)	(4,770,024)		17
18	Deferred Charges	101,237		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)	\$ 1,946,829	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,907,274	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 40,876	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,352		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,321		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	174,696		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 535,245	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,675		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)	\$ 81,675	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 616,920	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,290,354	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,907,274	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,637,616)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,637,616)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,009,208)	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)	\$ (1,009,208)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	4,937,178	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 4,937,178	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,290,354	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Canton# 0049296Report Period Beginning: 01/01/12Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,016,129	1
2	Discounts and Allowances for all Levels	(1,317,655)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,698,474	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,058,606	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,058,606	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	462	12
13	Barber and Beauty Care	9,740	13
14	Non-Patient Meals	7,686	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	128,317	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,016	19
20	Radiology and X-Ray	7,612	20
21	Other Medical Services	40,424	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 228,257	23
	D. Non-Operating Revenue		
24	Contributions	525	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 525	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Activities Income</u>	330	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 330	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,986,192	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	922,183	31
32	Health Care	2,584,732	32
33	General Administration	2,046,155	33
	B. Capital Expense		
34	Ownership	928,651	34
	C. Ancillary Expense		
35	Special Cost Centers	216,985	35
36	Provider Participation Fee	296,694	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,995,400	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,009,208)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,009,208)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,446,136	44
45	Private Pay - Net Inpatient Revenue	1,519,729	45
46	Medicare - Net Inpatient Revenue	959,706	46
47	Other-(specify) <u>Hospice</u>	245,860	47
48	Other-(specify) <u>Insurance</u>	527,043	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,698,474	49

* 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	2,049	2,239	\$ 74,089	\$ 33.09	1
2	Assistant Director of Nursing	3,216	3,515	96,368	27.42	2
3	Registered Nurses	14,243	15,564	392,271	25.20	3
4	Licensed Practical Nurses	18,739	20,476	433,405	21.17	4
5	CNAs & Orderlies	54,915	60,015	667,066	11.11	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	6,655	7,256	302,786	41.73	7
8	Rehab/Therapy Aides	6,158	6,714	185,822	27.68	8
9	Activity Director	3,389	3,705	47,707	12.88	9
10	Activity Assistants					10
11	Social Service Workers	3,890	4,241	82,508	19.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,567	21,391	223,571	10.45	15
16	Dishwashers					16
17	Maintenance Workers	1,854	2,026	47,077	23.24	17
18	Housekeepers	8,560	9,352	98,866	10.57	18
19	Laundry	3,985	4,361	38,701	8.87	19
20	Administrator	2,080	2,080	70,280	33.79	20
21	Assistant Administrator	235	235	6,226	26.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,430	12,587	247,819	19.69	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	1,552	1,698	23,336	13.74	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,613	1,758	20,704	11.78	33
34	TOTAL (lines 1 - 33)	164,130	179,213	\$ 3,058,602 *	\$ 17.07	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	15,000	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)		\$ 15,000		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount		
Nicole Friend	Administrator	0	\$ 70,280		
Rebecca Newble	Asst Administrator	0	6,226		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,506		
B. Administrative - Other					
Description			Amount		
Home Office Costs			\$ 261,651		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 261,651		
C. Professional Services					
Vendor/Payee	Type		Amount		
United Collectin Bureau Inc	Collection Services		\$ 135		
Caludon Kost Barnhrt Beal Walters	Legal Fees		713		
Littler Mendelson PC	Legal Fees		32,809		
(All the above legal are 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.)			\$ 33,657		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 58,414		
Unemployment Compensation Insurance			59,948		
FICA Taxes			218,877		
Employee Health Insurance			225,591		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Tuition Program			6,186		
Disability Payments					
401K			7,740		
Appreciation, other benefits, & mkting adj			6,598		
SMSP Company Match			32		
Employee Uniforms			2,598		
Home Office Allocation			24,311		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 610,295		
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			\$ 2,547		
Advertising: Employee Recruitment			5,417		
Health Care Worker Background Check (Indicate # of checks performed)		76	3,061		
Patient Background Checks		88	2,640		
Dues & Subscriptions			9,476		
Association Dues			9,594		
Advertising (Allow)			35,570		
Advertising (Non-All)			13,115		
Less: Non-allow association dues			(6,631)		
Less: Public Relations Expense			(35,570)		
Non-allowable advertising			(13,115)		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 26,104		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel			20,583		
Seminar Expense					
Entertainment Expense			()		
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 20,583		

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$2963

(3) Did the nursing home make political contributions or payments to a political action organization? Yes \$6631 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. \$ 42,339 Line 10, 2

(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. \$ 296,694
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. \$ 7,686

(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.