

		FOR BHF USE					

LL1

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: 0049452

Facility Name: Heartland of Henry

Address: 1650 Indian Town Road Henry 61537
Number City Zip Code

County: Marshall

Telephone Number: (309) 364-3905 Fax # (309) 364-2247

HFS ID Number:

Date of Initial License for Current Owners: 10/10/1988

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

Facility Name & ID Number Heartland of Henry# 0049452 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>94</u>	Skilled (SNF)	<u>94</u>	<u>34,404</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>94</u>	TOTALS	<u>94</u>	<u>34,404</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>6,903</u>	<u>14,347</u>	<u>6,994</u>	<u>28,244</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>6,903</u>	<u>14,347</u>	<u>6,994</u>	<u>28,244</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.10%

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 4/1/1989

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 66 and days of care provided 5,422Medicare 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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
	A. General Services										
1	Dietary	234,291	13,002	9,692	256,985		256,985		256,985		1
2	Food Purchase		180,517		180,517		180,517	(3,138)	177,379		2
3	Housekeeping	81,295	12,658	2,159	96,112		96,112		96,112		3
4	Laundry	54,463	14,645	42	69,150		69,150		69,150		4
5	Heat and Other Utilities			155,897	155,897	1,294	157,191		157,191		5
6	Maintenance	67,209	15,947	46,509	129,665		129,665		129,665		6
7	Other (specify):* Medical Waste			368	368		368		368		7
8	TOTAL General Services	437,258	236,769	214,667	888,694	1,294	889,988	(3,138)	886,850		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,665,403	122,336	76,924	1,864,663	8,061	1,872,724		1,872,724		10
10a	Therapy	633,338	6,332	20,846	660,516		660,516		660,516		10a
11	Activities	81,400	7,120	1,975	90,495		90,495		90,495		11
12	Social Services	81,405	5,279	1,311	87,995		87,995		87,995		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,461,546	141,067	116,056	2,718,669	8,061	2,726,730		2,726,730		16
	C. General Administration										
17	Administrative	91,089		268,598	359,687	(93,542)	266,145		266,145		17
18	Directors Fees										18
19	Professional Services			1,658	1,658		1,658	(640)	1,018		19
20	Dues, Fees, Subscriptions & Promotions			53,935	53,935		53,935	(38,305)	15,630		20
21	Clerical & General Office Expenses	182,187	35,136	146,681	364,004		364,004	(121,578)	242,426		21
22	Employee Benefits & Payroll Taxes			516,052	516,052	24,970	541,022		541,022		22
23	Inservice Training & Education			1,117	1,117		1,117		1,117		23
24	Travel and Seminar			29,782	29,782		29,782		29,782		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			516,507	516,507		516,507		516,507		26
27	Other (specify):*							(5)	(5)		27
28	TOTAL General Administration	273,276	35,136	1,534,330	1,842,742	(68,572)	1,774,170	(160,528)	1,613,642		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,172,080	412,972	1,865,053	5,450,105	(59,217)	5,390,888	(163,666)	5,227,222		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			258,376	258,376	9,170	267,546		267,546			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			741,040	741,040	50,047	791,087	(742,664)	48,423			32
33	Real Estate Taxes			136,218	136,218		136,218		136,218			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,193	25,193		25,193		25,193			35
36	Other (specify):*											36
37	TOTAL Ownership			1,160,827	1,160,827	59,217	1,220,044	(742,664)	477,380			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,471		117,471		117,471		117,471			39
40	Barber and Beauty Shops			18,852	18,852		18,852		18,852			40
41	Coffee and Gift Shops	14,063			14,063		14,063		14,063			41
42	Provider Participation Fee			288,348	288,348		288,348		288,348			42
43	Other (specify):* IV, X-ray& Lab		20,910	18,774	39,684		39,684		39,684			43
44	TOTAL Special Cost Centers	14,063	138,381	325,974	478,418		478,418		478,418			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,186,143	551,353	3,351,854	7,089,350		7,089,350	(906,330)	6,183,020			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,138)	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	(454)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,545)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(640)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,474)	21		24
25	Fund Raising, Advertising and Promotional	(38,305)	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	(762,769)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (906,330)		\$	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	2	
		Amount	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))	\$ (906,330)		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	2	3	4	
		Yes	No	Amount	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 Henry

Report Period Beginning:

Ending:

ID#0049452

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (13,311)	21	1
2	P/R O/H Alloc- Mktg	(3,805)	21	2
3	HCP Lease Interest	(742,664)	32	3
4	Vending Income	(2,989)	21	4
5	Misc Income		21	5
6	Activity Income		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	(762,769)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Henry # 0049452 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,138)	0	0	0	0	0	0	0	0	0	0	(3,138)	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	(3,138)	0	0	0	0	0	0	0	0	0	0	(3,138)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(640)	0	0	0	0	0	0	0	0	0	0	(640)	19
20	Fees, Subscriptions & Promotions	(38,305)	0	0	0	0	0	0	0	0	0	0	(38,305)	20
21	Clerical & General Office Expenses	(121,578)	0	0	0	0	0	0	0	0	0	0	(121,578)	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):*	(5)	0	0	0	0	0	0	0	0	0	0	(5)	27
28	TOTAL General Administration	(160,528)	0	0	0	0	0	0	0	0	0	0	(160,528)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(163,666)	0	0	0	0	0	0	0	0	0	0	(163,666)	29

Summary B

12/31/12

[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 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	See	Home Office Allocation	\$268,598	HCR Manor Care Services, LLC	100.00%	\$268,598	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,186,143	Heartland Employment Services, LLC	100.00%	3,186,143		4
5	V	10a	Therapy Management	11,107	Heartland Rehab Services, LLC	100.00%	11,107		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			\$3,465,848			\$3,465,848	\$ *	14

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

Facility Name & ID Number

Heartland of Henry

0049452

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			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								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
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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 Henry # 0049452 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	6,911,215	\$ 1,294	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs		0	6,911,215	0	2
3	5	Utilities - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs		0	6,911,215	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	419,407	305,829	6,911,215	724	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	6,911,215	7,337	5
6	10	Nursing - Direct to Midwest Divis	Accumulated Cost	517,936,312	48 NFs			6,911,215	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	66,682,648	33,182,703	6,911,215	115,229	7
8	17	General & Administrative - Direct	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	6,911,215	35,322	8
9	17	General & Administrative - Direct	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,308	6,911,215	24,505	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	7,480,805	0	6,911,215	12,927	10
11	22	Employee Benefits - Direct to All	Accumulated Cost	3,550,656,576	354 NFs	6,187,019	0	6,911,215	12,043	11
12	22	Employee Benefits - Direct to Mid	Accumulated Cost	517,936,312	48 NFs		0	6,911,215	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	4,579,765	0	6,911,215	7,914	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474	0	6,911,215	1,256	14
15	30	Depreciation - Direct to Midwest	Accumulated Cost	517,936,312	48 NFs		0	6,911,215	0	15
16										16
17										17
18	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		6,911,215	44,706	18
19	32	Directly Assigned Interest	Not Allocated			18,513,013			5,341	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		\$ 268,598	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			\$ 81,733	\$ 81,733		0.0653	\$ 5,341	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6												6		
7	Home Office Pooled Interest										44,706	7		
8	Interest Income Other										(1,624)	8		
9	TOTAL Facility Related						\$ 81,733	\$ 81,733			\$ 48,423	9		
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 81,733	\$ 81,733			\$ 48,423	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	132,745	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.)		\$	134,482	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,736	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	134,482	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.		\$	136,218	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	104,469	8	
		2008	110,954	9	
		2009	110,954	10	
		2010	132,745	11	
		2011	134,482	12	
				13	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 Henry COUNTY Marshall
FACILITY IDPH LICENSE NUMBER 0049452
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)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>03-09-326-001</u>	<u>See Attached</u>	\$ <u>134,481.50</u>	\$ <u>134,481.50</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>134,481.50</u></u>	\$ <u><u>134,481.50</u></u>

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:	26,130	B. General Construction Type:	Exterior	Masonry	Frame	Steel, 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).

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	\$ 174,000	1
2					2
3	TOTALS			\$ 174,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1988	1988	\$ 1,748,953	\$ 53,363		\$ 53,363	\$	\$ 1,163,044	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					112,830		112,830		1,372,570	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	7/1/03 Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,948,456	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	70

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 2,948,456	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	1
2	PAINTING FOR RESIDENTS ROOMS	2000	3,000						2
3	DOOR HARDWARE	2000	906						3
4	PAINTING	2000	730						4
5	PAINTING	2000	3,000						5
6	DRYWALL	2000	(3,000)						6
7	SMOKE DAMPERS	2000	7,280						7
8	ADDL'T COST SMOKE DAMPERS	2000	658						8
9	TOTAL DOORS	2000	73						9
10	WALLCOVERING	2000	610						10
11	WALLCOVERING	2000	170						11
12	WALLCOVERING	2000	709						12
13	WALLCOVERING	2000	519						13
14		2000	299						14
15	CEILING								15
16	CUSTOM WORKSTATION	2001	1,225						16
17	PAINT & WALLCOVERING	2001	2,067						17
18	WALLCOVERING - LOUNGE RENOVATION	2001	1,760						18
19	WINDOWS	2001	557						19
20	HOT WATER HEATERS	2001	855						20
21	DRAPES	2001	7,900						21
22	CARPET	2001	2,980						22
23	ADDTL COSTS FOR CARPET	2001	29,586						23
24	CARPET	2001	2,260						24
25	WALLCOVERING	2001	500						25
26	WALLCOVERING	2001	516						26
27	CARPENTRY - LOUNGE RENOVATION	2001	90						27
28	DRAPES, SHADES, BLINDS - LOUNGE RENOVATION	2001	6,002						28
29	CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION	2001	1,109						29
30	PAINTING, WALLCOVERING - LOUNGE RENOVATION	2001	10,360						30
31	PLUMBING - LOUNGE RENOVATION	2001	9,691						31
32	CONCRETE	2001	4,425						32
33		2001	2,248						33
34	TOTAL (lines 1 thru 33)		\$ 3,047,541	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	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 12B, Carried Forward		\$ 3,047,541	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,268,248	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	34

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

Facility Name & ID Number Heartland of Henry

0049452

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		\$ 3,268,248	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,528,481	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	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 12D, Carried Forward		\$ 3,528,481	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						19
20	2 concrete sidewalks	2008	2,600						20
21	CARPENTRY	2008	500						21
22	0907 EMERGENCY LIGHTING	2008	6,357						22
23	0907 EMERGENCY LIGHTING	2008	38,409						23
24	0907 EMERGENCY LIGHTING	2008	6,454						24
25	0907 EMERGENCY LIGHTING	2008	4,450						25
26	AC CONDENSING UNIT	2008	4,287						26
27	ELECTRICAL FOR TVS	2008	10,260						27
28	SERVICE DOOR ENTRANCE1	2008	5,365						28
29	FIRE RATED SHUTTER	2008	4,806						29
30	DOOR FOR ENTRANCE	2008	5,365						30
31	entrance doors	2008	1,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,711,720	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	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		\$ 3,711,720	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	1
2	BI 022449 0309 FLOORING REPLACEMENT	2010	25,203						2
3	LI 022448 back door concrete pad	2010	4,246						3
4	LI 022459 5' wide sidewalk, therapy	2010	4,038						4
5	LI 022460 Seal & strip pkg lot	2010	4,978						5
6	BI 022463 Radiant Heat Panels	2011	7,450						6
7	BI 022469 135 Sprinkler Heads	2011	10,215						7
8	BI 022481 PT reno-prime/paint ceilings, vwc removal	2011	41,370						8
9	BI 022482 0211 PARKING LOT	2011	83,215						9
10	BI 022484 Wallcovering	2011	19,675						10
11	000000022490 GAS WATER HEATER	2012	5,395						11
12	000000022496 0212 Nurse Call System	2012	1,353						12
13	000000022497 0112 Fire Alarm System	2012	38,093						13
14	000000022498 0112 Fire Alarm System	2012	1,184						14
15	000000022499 ADJ ASSET #22497-fire alarm system	2012	2,898						15
16	000000022500 ADJ ASSET #22497-fire alarm system	2012	6,762						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,967,796	\$ 166,193		\$ 166,193	\$	\$ 2,535,614	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	\$1,698,188	\$92,183	\$92,183	\$		\$1,543,584	71
72	Current Year Purchases	79,293						72
73	Fully Depreciated Assets							73
74	Home Office			9,170	9,170			74
75	TOTALS	\$1,777,481	\$92,183	\$101,353	\$9,170		\$1,543,584	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,919,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$258,376	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$267,546	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,170	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,079,198	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?
16. Rental Amount for movable equipment: \$ 17,158 Description: 02 Concentrators, wheelchairs, gerichairs, electric beds
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	Various	\$	\$ 8,035	17
18					18
19				above figure includes	19
20				gas & maintenance too	20
21	TOTAL		\$	\$ 8,035	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. /2013 \$
13. /2014 \$
14. /2015 \$

* 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.)

		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	2779 hrs	\$ 102,316		\$	\$ 1,643	2,779	\$ 103,959	1
2	Licensed Speech and Language Development Therapist	10a	1208 hrs	44,462				1,208	44,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4841 hrs	178,225			4,689	4,841	182,914	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				117,471		117,471	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					20,910		20,910	12
13	Other (specify): X-ray & Lab	43, 3				18,774			18,774	13
14	TOTAL			\$ 325,003		\$ 18,774	\$ 144,713	8,828	\$ 488,490	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	\$ 25,149	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 204,425)	792,245		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)	\$ 817,394	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	3,967,796		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,777,481		16
17	Accumulated Depreciation (book methods)	(4,079,198)		17
18	Deferred Charges	6,847,053		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)	\$ 8,687,132	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,504,526	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 59,619	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,409		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	134,481		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	127,404		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 573,913	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,733		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)	\$ 81,733	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 655,646	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,848,880	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,504,526	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,539,066	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,539,066	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(21,449)	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)	\$ (21,449)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	6,331,263	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 6,331,263	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,848,880	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Henry# 0049452Report 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	\$ 6,928,806	1
2	Discounts and Allowances for all Levels	(1,704,458)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,224,348	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,555,223	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,555,223	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,994	12
13	Barber and Beauty Care	24,255	13
14	Non-Patient Meals	3,138	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,850	16
17	Sale of Drugs	195,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,389	19
20	Radiology and X-Ray	3,618	20
21	Other Medical Services	37,042	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 286,785	23
	D. Non-Operating Revenue		
24	Contributions	1,545	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,545	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,067,901	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	888,694	31
32	Health Care	2,718,669	32
33	General Administration	1,842,742	33
	B. Capital Expense		
34	Ownership	1,160,827	34
	C. Ancillary Expense		
35	Special Cost Centers	190,070	35
36	Provider Participation Fee	288,348	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,089,350	40
41	Income before Income Taxes (line 30 minus line 40)**	(21,449)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (21,449)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 790,276	44
45	Private Pay - Net Inpatient Revenue	2,756,958	45
46	Medicare - Net Inpatient Revenue	1,347,723	46
47	Other-(specify) <u>Hospice</u>	26,677	47
48	Other-(specify) <u>Insurance</u>	302,714	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,224,348	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	2,006	2,205	\$ 78,925	\$ 35.79	1
2	Assistant Director of Nursing	2,667	2,932	74,735	25.49	2
3	Registered Nurses	16,033	17,624	421,908	23.94	3
4	Licensed Practical Nurses	15,746	17,307	351,017	20.28	4
5	CNAs & Orderlies	58,526	64,404	706,711	10.97	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	8,828	9,692	356,812	36.82	7
8	Rehab/Therapy Aides	8,729	9,583	276,526	28.86	8
9	Activity Director	6,439	7,085	81,400	11.49	9
10	Activity Assistants					10
11	Social Service Workers	3,753	4,130	81,405	19.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,252	22,280	234,291	10.52	15
16	Dishwashers					16
17	Maintenance Workers	3,221	3,545	67,209	18.96	17
18	Housekeepers	7,132	7,848	81,295	10.36	18
19	Laundry	5,189	5,710	54,463	9.54	19
20	Administrator	2,080	2,080	91,089	43.79	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,661	8,513	165,071	19.39	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	1,660	1,827	32,107	17.57	31
32	Other Health Care(specify)					32
33	Other(specify)Hospitality	1,341	1,475	14,063	9.53	33
34	TOTAL (lines 1 - 33)	171,263	188,240	\$ 3,169,027 *	\$ 16.84	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.

STATE OF ILLINOIS

0049452

Report Period Beginning:

01/01/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

Heartland of Henry

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Susan Legner		Administrator	0	\$ 91,089	Workers' Compensation Insurance		\$ 18,317	IDPH License Fee		\$ 2,345	
					Unemployment Compensation Insurance		55,034	Advertising: Employee Recruitment		1,798	
					FICA Taxes		224,118	Health Care Worker Background Check		5,303	
					Employee Health Insurance		199,146	(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		3,090	
					Tuition Program			Association Dues		10,011	
					Disability Payments		4,895	Advertising (Allow)		11,422	
					401K & Marketing adj.		10,388	Advertising (Non-All)		19,966	
					Appreciation, other benefits		2,351	Less: Non-allow association dues		(6,917)	
					SMSP Company Match		32	Less: Public Relations Expense		(11,422)	
					Employee Uniforms		1,771	Non-allowable advertising		(19,966)	
					Home Office Allocation		24,970	Yellow page advertising (			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 91,089	TOTAL (agree to Schedule V, line 22, col.8)			\$ 541,022	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,630
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Description				Amount	Description		Line #	Amount	Description		Amount
Home Office Costs				\$ 268,598					Out-of-State Travel		\$
									In-State Travel		29,782
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 268,598							
C. Professional Services											
Vendor/Payee		Type		Amount							
United Collection Bureau Inc.		Collection Services		\$ 1,018							
Michael T. Mahoney, LTD		Legal Fees		640							
(All the above legal fees were adjusted off via page 5, Line 22, therefore no invoices are attached)											
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 1,658	TOTAL			\$	Entertainment Expense (		
									(agree to Sch. V, line 24, col. 8)		\$ 29,782

* 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 \$3094

(3)

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

Yes \$6917

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.

\$

41,052

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.

\$

288,348

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.

\$

3,138

(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.