

Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 12/01/2005

	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>76</u>	Skilled (SNF)	<u>84</u>	<u>27,988</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>76</u>	TOTALS	<u>84</u>	<u>27,988</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>504</u>	<u>8,483</u>	<u>9,012</u>	<u>17,999</u>	8
9	SNF/PED					9
10	ICF	<u>5,764</u>	<u>868</u>	<u>200</u>	<u>6,832</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,268</u>	<u>9,351</u>	<u>9,212</u>	<u>24,831</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.72%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 11/01/81

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

YES Date 11/01/81 NO

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

YES NO If YES, enter number of beds certified 84 and days of care provided 7,028Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	120,668	9,536	16,511	146,715	2,264	148,979		148,979		1
2	Food Purchase		137,610		137,610		137,610	(1,576)	136,034		2
3	Housekeeping	84,804	16,799	1,560	103,163		103,163		103,163		3
4	Laundry	24,599	31,683	20,214	76,496		76,496		76,496		4
5	Heat and Other Utilities			127,253	127,253	4,581	131,834	(2,154)	129,680		5
6	Maintenance	58,201	4,162	46,244	108,607		108,607		108,607		6
7	Other (specify):* Med Waste			572	572		572		572		7
8	TOTAL General Services	288,272	199,790	212,354	700,416	6,845	707,261	(3,730)	703,531		8
	B. Health Care and Programs										
9	Medical Director			9,750	9,750		9,750		9,750		9
10	Nursing and Medical Records	1,270,748	103,516	47,336	1,421,600	8,217	1,429,817	(14,372)	1,415,445		10
10a	Therapy	21,338	2,853	438,888	463,079		463,079		463,079		10a
11	Activities	37,242	5,411	1,485	44,138		44,138	(717)	43,421		11
12	Social Services	69,463	38	2,116	71,617		71,617		71,617		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,398,791	111,818	499,575	2,010,184	8,217	2,018,401	(15,089)	2,003,312		16
	C. General Administration										
17	Administrative	68,674		275,619	344,293	(62,131)	282,162		282,162		17
18	Directors Fees										18
19	Professional Services			336	336		336	(336)			19
20	Dues, Fees, Subscriptions & Promotions			73,233	73,233		73,233	(42,022)	31,211		20
21	Clerical & General Office Expenses	139,797	40,226	646,412	826,435		826,435	(612,298)	214,137		21
22	Employee Benefits & Payroll Taxes			430,952	430,952	34,141	465,093		465,093		22
23	Inservice Training & Education			3,790	3,790		3,790		3,790		23
24	Travel and Seminar			5,723	5,723		5,723		5,723		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,448	77,448		77,448		77,448		26
27	Other (specify):* Personal Purch			40	40		40	(40)			27
28	TOTAL General Administration	208,471	40,226	1,513,553	1,762,250	(27,990)	1,734,260	(654,696)	1,079,564		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,895,534	351,834	2,225,482	4,472,850	(12,928)	4,459,922	(673,515)	3,786,407		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.

Facility Name & ID Number Heartland Health Care Center-Galesburg #0041806 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			282,264	282,264	12,928	295,192		295,192			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,276	60,276		60,276	(59)	60,217			32
33	Real Estate Taxes			64,370	64,370		64,370	14,947	79,317			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			44,098	44,098		44,098		44,098			35
36	Other (specify):* <i>G/L Assets</i>			3,910	3,910		3,910	(3,910)				36
37	TOTAL Ownership			454,918	454,918	12,928	467,846	10,978	478,824			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,909		219,909		219,909		219,909			39
40	Barber and Beauty Shops		78,760	8,039	86,799		86,799		86,799			40
41	Coffee and Gift Shops	4,430			4,430		4,430		4,430			41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* <i>IV Therapy</i>		41,263		41,263		41,263		41,263			43
44	TOTAL Special Cost Centers	4,430	339,932	49,649	394,011		394,011		394,011			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,899,964	691,766	2,730,049	5,321,779		5,321,779	(662,537)	4,659,242			45

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

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (697)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,576)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,154)	5		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	(59)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	2,621	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(14,372)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,000)	21		18
19	Entertainment				19
20	Contributions	(400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(336)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(607,829)	21		24
25	Fund Raising, Advertising and Promotional	(42,022)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	14,947	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,660)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (662,537)		\$	30

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))	\$ (662,537)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

Heartland Health Care Center-Galesburg

ID# 0041806

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	G/L ASSETS	\$ (3,910)	36	1
2	CUSTOMER REIMBURSEMENT	(1,690)	21	2
3	ACTIVITIES INCOME	(20)	11	3
4	PERSONAL PURCHASE	(40)	27	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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	(5,660)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(1,576)	0	0	0	0	0	0	0	0	0	0	(1,576)	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	(2,154)	0	0	0	0	0	0	0	0	0	0	(2,154)	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	(3,730)	0	0	0	0	0	0	0	0	0	0	(3,730)	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	(14,372)	0	0	0	0	0	0	0	0	0	0	(14,372)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(717)	0	0	0	0	0	0	0	0	0	0	(717)	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	(15,089)	0	0	0	0	0	0	0	0	0	0	(15,089)	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	(336)	0	0	0	0	0	0	0	0	0	0	(336)	19
20	Fees, Subscriptions & Promotions	(42,022)	0	0	0	0	0	0	0	0	0	0	(42,022)	20
21	Clerical & General Office Expenses	(612,298)	0	0	0	0	0	0	0	0	0	0	(612,298)	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):*	(40)	0	0	0	0	0	0	0	0	0	0	(40)	27
28	TOTAL General Administration	(654,696)	0	0	0	0	0	0	0	0	0	0	(654,696)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(673,515)	0	0	0	0	0	0	0	0	0	0	(673,515)	29

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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

	Capital Expense	PAGES	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	(59)	0	0	0	0	0	0	0	0	0	0	(59)	32
33	Real Estate Taxes	14,947	0	0	0	0	0	0	0	0	0	0	14,947	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):*	(3,910)	0	0	0	0	0	0	0	0	0	0	(3,910)	36
37	TOTAL Ownership	10,978	0	10,978	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)	(662,537)	0	(662,537)	45									

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			
Manor Care, Inc						

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	\$ 275,619	HCR Manor Care, Inc	100.00%	\$ 275,619	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	11,508	Heartland Management Services	100.00%	11,508		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 287,127			\$ 287,127	\$ *	14

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

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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

Name of Related Organization HCR Manor Care, Inc
 Street Address 333 North Summit St
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5494

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

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	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	\$ 1,107,111	\$ 591,572	5,115,234	\$ 2,264	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			5,115,234	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	266,575		5,115,234	545	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		5,115,234	4,034	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	5,115,234	1,577	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	5,115,234	6,640	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	5,115,234	50,688	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	5,115,234	162,802	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		5,115,234	13,011	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		5,115,234	21,130	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			5,115,234	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		5,115,234	12,928	12
13										13
14	32	Interest								14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 156,573,224	\$ 69,154,917		\$ 275,619	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	National City Bank, Trustee		X	Finance Capital Additions	N/A		\$ 964,387	\$ 964,387			\$ 60,276	1				
2												2				
3												3				
4								Income			(59)	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 964,387	\$ 964,387			\$ 60,217	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 964,387	\$ 964,387			\$ 60,217	15				

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 49,424	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.)		\$ 64,370	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 14,946	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 64,370	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.		\$ 79,317	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	45,579	8
	2001	48,166	9
	2002	52,783	10
	2003	53,412	11
	2004	64,370	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0041806

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>9910427017</u>	<u>See Attached</u>	<u>\$ 64,370.28</u>	<u>\$ 64,370.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 64,370.28	\$ 64,370.28

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,825 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	<u>Facility</u>		<u>1983</u>	<u>\$ 54,305</u>	<u>1</u>
2	<u>Facility</u>		<u>2003</u>	<u>67,630</u>	<u>2</u>
3	TOTALS			\$ 121,935	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1964	1964	\$ 407,801	\$ 14,253		\$ 14,253		\$ 437,494	4
5	7			2003	570,110						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					171,764		171,764		1,073,746	9
10	Building Improvements			1968	73						10
11	Building Improvements			1969	1,059						11
12	Building Improvements			1970	1,083						12
13	Building Improvements			1971	10,602						13
14	Building Improvements			1972	5,946						14
15	Building Improvements			1973	758						15
16	Building Improvements			1974	817						16
17	Building Improvements			1975	3,645						17
18	Building Improvements			1978	19,333						18
19	Land Improvements			1983	1,350						19
20	Building Improvements			1984	21,913						20
21	Building Improvements			1985	42,479						21
22	Land Improvements			1985	8,457						22
23	Building Improvements			1986	23,347						23
24	Land Improvements			1986	2,349						24
25	Building Improvements			1987	19,172						25
26	Building Improvements			1988	14,265						26
27	Land Improvements			1988	1,470						27
28	Building Improvements			1989	36,615						28
29	Land Improvements			1990	1,500						29
30	Building Improvements			1990	27,793						30
31	Building Improvements			1991	9,501						31
32	Building Improvements			1992	24,536						32
33	Building Improvements			1993	16,600						33
34	Land Improvements			1994	3,095						34
35	Building Improvements			1994	1,278						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	
37	Land Improvements	1995	\$ 1,098	\$		\$	\$	\$	37
38	Building Improvements	1995	14,214						38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693						39
40	engineering fees, demolition, masonry, concrete, drywall,								40
41	windows, doors, wood trim, paint, counter tops, electrical								41
42	Building Improvements : Wallcovering	1996	79,684						42
43	Building Improvements : Carpet and vinyl	1996	33,131						43
44	Building Improvements : Ceramic flooring	1996	40,886						44
45	Building Improvements : Millwork	1996	25,990						45
46	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580						46
47	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								47
48	vinyl flooring								48
49	Building Improvements : Doors	1997	10,728						49
50	Building Improvements : Electrical composite, automatic doors,	1997	38,947						50
51	metal doors, fire alarm system								51
52	Building Improvements : Capalo	1997	2,500						52
53	Building Improvements : Generator	1997	7,743						53
54	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						54
55	Building Improvements : Onan Genator	1997	17,482						55
56	Building Improvements : Soffits, gutters & trim	1997	9,962						56
57	Building Improvements : Generator	1997	24,885						57
58	Land Improvements - Sidewald	1998	7,988						58
59	Building Improvements - Fire Prevention System	1998	35,013						59
60	Building Improvements - HVAC	1997	42,499						60
61	Sidewalk	1999	7,988						61
62	Sidewalk	1999	900						62
63	Overhead from const	1999	2,681						63
64	Power control wiring for ne	1999	2,392						64
65	Sprinkler system upgrade	1999	19,107						65
66	Air compressor	1999	598						66
67	Laundry room floor	1999	1,800						67
68	Sprinkler upgrade	1999	23,940						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,270,932	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	70

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

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,270,932	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	1
2	Fire sprinkler system	1999	2,971						2
3	Boiler	1999	33,600						3
4	HVAC upgrade	1999	2,420						4
5	Building improvements	1999	1,200						5
6	SMOKING HUT	2000	4,950						6
7	CONCRETE FOR SMOKE HUT	2000	350						7
8	CABINETRY	2000	3,690						8
9	ELECTRICAL	2000	20,205						9
10	ADDT'L COST SMOKING HUT	2000	645						10
11	ELECTRICAL	2000	10,880						11
12	ELECTRICAL	2000	3,454						12
13	HVAC	2000	21,662						13
14	ELECTRICAL/NEW OFFICE	2000	860						14
15	CABINETS	2000	1,369						15
16	HVAC	2000	1,736						16
17	HVAC	2000	193						17
18	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						18
19	AIR / HUMIDIFIER COIL	2001	5,233						19
20	CANOPY	2001	1,200						20
21	CONCRETE PATIO	2001	5,500						21
22	VWC	2002	1,172						22
23	Carpet	2002	1,534						23
24	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						24
25	Border	2002	111						25
26	Border	2002	125						26
27	Brick Work	2002	5,787						27
28	Addition Cost Brick Work	2002	643						28
29	Artwork	2002	2,219						29
30	Paint & Wallcovering	2002	2,810						30
31	Paint & Wallcovering	2002	3,122						31
32	Overhead & Interest	2003	431						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,524,642	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	34

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

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,524,642	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	1
2	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						2
3	Paint, Flooring & VWC	2003	12,182						3
4	Paint, Flooring & VWC	2003	1,354						4
5	Freight on Carpet	2003	56						5
6	Carpet, Wallcovering and Corner Guards	2003	12,197						6
7	Developers Costs - Architect & Engineering Fees	2003	96,312						7
8	Developers Costs - T&E, Reprod.,Permit & Plan Review Fees	2003	15,798						8
9	Developers Costs - Overhead	2003	152,775						9
10	Developers Costs - Interest	2003	13,748						10
11	Millwork	2003	4,664						11
12	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						12
13	Site Work/Preparation	2003	74,492						13
14	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45	2003	(627)						14
15	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	2003	(900)						15
16	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	2003	(2,681)						16
17	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	2003	(1,740)						17
18	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2003	(15,146)						18
19	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2003	(6,839)						19
20	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2003	(2,219)						20
21	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)						21
22	CONSULTING SERVICES-PHASE 2 ADDITION	2003	3,200						22
23	ARCHITECTURAL SERVICES	2003	9,117						23
24	ENGINEERING COST-CENTRAL BATH RENOV	2004	4,013						24
25	ENGINEERING COST-CENTRAL BATH RENOV	2004	6,479						25
26	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	723						26
27	ARCHITECTURAL COST-CENTRAL BATH RENOV	2004	180						27
28	ENGINEERING COST-CENTRAL BATH RENOV	2004	450						28
29	VINYL WALL COVERING	2004	266						29
30	BORDER	2004	948						30
31	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	2,986						31
32	BORDER FOR BATH	2004	85						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,947,866	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	34

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

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,947,866	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	1
2	ENGINEERING COST-CENTRAL BATH RENOV	2004	2,794						2
3	CARPET & COVE BASE	2004	6,273						3
4	VINYL WALL COVERING	2004	8,199						4
5	GAZEBO	2004	6,389						5
6	MATERIAL & SVCS-NURSING STA & BATH	2004	93,206						6
7	VINYL WALL COVERING	2005	497						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	TOTAL (lines 1 thru 33)		\$ 3,065,224	\$ 186,017		\$ 186,017	\$	\$ 1,511,240	34

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

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,237,138	\$ 96,247	\$ 96,247	\$		\$ 885,903	71
72	Current Year Purchases	61,398						72
73	Fully Depreciated Assets							73
74	H/O Allocation			12,928	12,928			74
75	TOTALS	\$ 1,298,536	\$ 96,247	\$ 109,175	\$ 12,928		\$ 885,903	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van With		\$ 20,718	\$	\$	\$		\$ 20,718	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			\$ 20,718	\$	\$	\$		\$ 20,718	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)	\$ 4,506,413	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,264	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 295,192	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,928	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,417,861	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	Construction in Progress	\$ 1,143,237	92
93			93
94			94
95		\$ 1,143,237	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: N/A

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:	<u>N/A</u>			\$			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.	<u> </u> /2006	\$ <u> </u>
13.	<u> </u> /2007	\$ <u> </u>
14.	<u> </u> /2008	\$ <u> </u>

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: \$ 44,098 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	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	404 hrs	\$ 10,909	7,397	\$ 184,937	\$ 1,281	7,801	\$ 197,127	1
2	Licensed Speech and Language Development Therapist	10a	203 hrs	5,486		82,287	767	203	88,540	2
3	Licensed Recreational Therapist		hrs		3,291			3,291		3
4	Licensed Physical Therapist	10a	183 hrs	4,943	6,832	170,800	805	7,015	176,548	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				219,909		219,909	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab,X-Ray	10,Col 3, 39				79,624			79,624	13
14	TOTAL			\$ 21,338	17,520	\$ 517,648	\$ 222,762	18,310	\$ 761,748	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.

Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806Report Period Beginning: 01/01/2005

Ending:

12/31/2005**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2005

(last day of reporting year)

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	\$ (118,573)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (359,174))	889,435		3
4	Supply Inventory (priced at)	30,474		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	780		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 802,116	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	121,935		13
14	Buildings, at Historical Cost	3,065,223		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,319,258		16
17	Accumulated Depreciation (book methods)	(2,417,861)		17
18	Deferred Charges			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): <u>CIP</u>	1,143,237		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,231,792	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,033,908	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,270	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,284		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,370		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	134,292		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 381,216	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	964,387		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)	\$ 964,387	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,345,603	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,688,305	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,033,908	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,002,451	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,002,451	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(359,730)	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)	\$ (359,730)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,045,584	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,045,584	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,688,305	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806Report Period Beginning: 01/01/2005Ending: 12/31/2005**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,707,536	1
2	Discounts and Allowances for all Levels	(450,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,257,409	3
B. Ancillary Revenue			
4	Day Care	697	4
5	Other Care for Outpatients		5
6	Therapy	1,249,242	6
7	Oxygen	11,889	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,261,828	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	764	12
13	Barber and Beauty Care	9,395	13
14	Non-Patient Meals	852	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	321,985	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,175	19
20	Radiology and X-Ray	40,556	20
21	Other Medical Services	9,026	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 442,753	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	59	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59	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)	\$ 4,962,049	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	700,416	31
32	Health Care	2,010,184	32
33	General Administration	1,762,250	33
B. Capital Expense			
34	Ownership	454,918	34
C. Ancillary Expense			
35	Special Cost Centers	394,011	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,321,779	40
41	Income before Income Taxes (line 30 minus line 40)**	(359,730)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (359,730)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

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	1,976	2,155	\$ 54,812	\$ 25.43	1
2	Assistant Director of Nursing	3,713	4,049	96,216	23.76	2
3	Registered Nurses	12,481	13,612	296,043	21.75	3
4	Licensed Practical Nurses	15,106	16,475	269,227	16.34	4
5	CNAs & Orderlies	51,597	56,271	537,378	9.55	5
6	CNA Trainees					6
7	Licensed Therapist	700	778	21,010	27.01	7
8	Rehab/Therapy Aides	28	31	328	10.58	8
9	Activity Director					9
10	Activity Assistants	3,034	3,313	37,242	11.24	10
11	Social Service Workers	3,732	4,076	69,463	17.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,695	14,935	120,668	8.08	15
16	Dishwashers					16
17	Maintenance Workers	3,855	4,204	58,201	13.84	17
18	Housekeepers	8,884	9,708	84,804	8.74	18
19	Laundry	2,792	3,039	24,599	8.09	19
20	Administrator	2,306	2,306	68,674	29.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,714	10,672	144,227	13.51	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	1,826	1,984	17,072	8.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,439	147,608	\$ 1,899,964 *	\$ 12.87	34

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

** See instructions.

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	9,750	Line 9 Col 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)		\$ 9,750		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

Facility Name & ID Number Heartland Health Care Center-Galesburg

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 \$ 4,365
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes, \$ 1,439
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 84
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,312 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 41,610
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. \$ 852
- (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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.