

		FOR BHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0041814

Facility Name: Heartland Health Care Center-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: 344402510013

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 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) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
	(Title) <u>Vice President of Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u>	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 Health Care Center-Henry

0041814 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 4/22/2005

	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>85</u>	Skilled (SNF)	<u>94</u>	<u>34,190</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>8</u>	Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>94</u>	<u>34,190</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,893</u>	<u>6,152</u>	<u>6,153</u>	<u>15,198</u>	8
9	SNF/PED					9
10	ICF	<u>1,547</u>	<u>10,925</u>	<u>1</u>	<u>12,473</u>	10
11	ICF/DD					11
12	SC		<u>446</u>		<u>446</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,440</u>	<u>17,523</u>	<u>6,154</u>	<u>28,117</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.24%

D. How many bed-hold days during this year were paid by the Department? 9 (Do not include bed-hold days in Section B.)

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

N/A

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

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

YES NO

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

YES NO

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

Date started 04/01/89

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

YES Date 04/01/89 NO

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

YES NO If YES, enter number of beds certified 52 and days of care provided 5,461

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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	185,389	12,489	8,266	206,144	1,724	207,868		207,868		1
2	Food Purchase		133,453		133,453		133,453	(9,064)	124,389		2
3	Housekeeping	70,687	12,080	248	83,015		83,015		83,015		3
4	Laundry	44,854	8,806	124	53,784		53,784		53,784		4
5	Heat and Other Utilities			103,373	103,373	3,490	106,863	(4,372)	102,491		5
6	Maintenance	23,758	8,845	37,281	69,884		69,884		69,884		6
7	Other (specify):* Med Waste			588	588		588		588		7
8	TOTAL General Services	324,688	175,673	149,880	650,241	5,214	655,455	(13,436)	642,019		8
	B. Health Care and Programs										
9	Medical Director			5,850	5,850		5,850		5,850		9
10	Nursing and Medical Records	1,298,488	72,430	19,847	1,390,765	6,260	1,397,025		1,397,025		10
10a	Therapy	21,087	4,896	291,617	317,600		317,600		317,600		10a
11	Activities	34,696	3,876	1,246	39,818		39,818		39,818		11
12	Social Services	58,685	769	695	60,149		60,149		60,149		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,412,956	81,971	319,255	1,814,182	6,260	1,820,442		1,820,442		16
	C. General Administration										
17	Administrative	77,624		209,961	287,585	(47,329)	240,256		240,256		17
18	Directors Fees										18
19	Professional Services			14,625	14,625		14,625	(14,625)			19
20	Dues, Fees, Subscriptions & Promotions			46,660	46,660		46,660	(30,264)	16,396		20
21	Clerical & General Office Expenses	93,614	34,655	(19,700)	108,569		108,569	30,184	138,753		21
22	Employee Benefits & Payroll Taxes			386,997	386,997	26,007	413,004		413,004		22
23	Inservice Training & Education			1,930	1,930		1,930		1,930		23
24	Travel and Seminar			9,905	9,905		9,905		9,905		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			95,172	95,172		95,172		95,172		26
27	Other (specify):* Personal Purch			181	181		181	(181)			27
28	TOTAL General Administration	171,238	34,655	745,731	951,624	(21,322)	930,302	(14,886)	915,416		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,908,882	292,299	1,214,866	3,416,047	(9,848)	3,406,199	(28,322)	3,377,877		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-Henry #0041814 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			233,722	233,722	9,848	243,570		243,570			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,112	5,112		5,112	(100)	5,012			32
33	Real Estate Taxes			97,268	97,268		97,268	(3,552)	93,716			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,473	19,473		19,473		19,473			35
36	Other (specify):* <i>G/L Assets</i>			5,681	5,681		5,681	(5,681)				36
37	TOTAL Ownership			361,256	361,256	9,848	371,104	(9,333)	361,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,708	8,991	106,699		106,699		106,699			39
40	Barber and Beauty Shops			12,329	12,329		12,329		12,329			40
41	Coffee and Gift Shops	23,984			23,984		23,984		23,984			41
42	Provider Participation Fee			49,967	49,967		49,967		49,967			42
43	Other (specify):* <i>IV Therapy</i>		20,010		20,010		20,010		20,010			43
44	TOTAL Special Cost Centers	23,984	117,718	71,287	212,989		212,989		212,989			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,932,866	410,017	1,647,409	3,990,292		3,990,292	(37,655)	3,952,637			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-Henry

0041814

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,064)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,372)	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	(100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(85)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,625)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	41,318	21		24
25	Fund Raising, Advertising and Promotional	(30,264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,552)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,782)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,655)		\$	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))	\$ (37,655)		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-Henry

ID# 0041814

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PHONE	\$ (4)	21	1
2	G/L ASSETS	(5,681)	36	2
3	CUSTOMER REIMBURSEMENT	(3,866)	21	3
4	TRANSPORTATION REVENUE	(7,050)	21	4
5	PERSONAL PURCHASES	(181)	27	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	(16,782)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	(9,064)	0	0	0	0	0	0	0	0	0	0	(9,064)	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	(4,372)	0	0	0	0	0	0	0	0	0	0	(4,372)	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	(13,436)	0	0	0	0	0	0	0	0	0	0	(13,436)	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	(14,625)	0	0	0	0	0	0	0	0	0	0	(14,625)	19
20	Fees, Subscriptions & Promotions	(30,264)	0	0	0	0	0	0	0	0	0	0	(30,264)	20
21	Clerical & General Office Expenses	30,184	0	0	0	0	0	0	0	0	0	0	30,184	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):*	(181)	0	0	0	0	0	0	0	0	0	0	(181)	27
28	TOTAL General Administration	(14,886)	0	0	0	0	0	0	0	0	0	0	(14,886)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,322)	0	0	0	0	0	0	0	0	0	0	(28,322)	29

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	32
33	Real Estate Taxes	(3,552)	0	0	0	0	0	0	0	0	0	0	(3,552)	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):*	(5,681)	0	0	0	0	0	0	0	0	0	0	(5,681)	36
37	TOTAL Ownership	(9,333)	0	(9,333)	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)	(37,655)	0	(37,655)	45									

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

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	\$ 209,961	HCR Manor Care, Inc	100.00%	\$ 209,961	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	8,106	Heartland Management Services	100.00%	8,106	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 218,067			\$ 218,067	\$ *

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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-Henry

0041814

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

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

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

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	3,896,672	\$ 1,724	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			3,896,672	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		3,896,672	417	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		3,896,672	3,073	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	3,896,672	1,201	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,945,092	2,235,491	3,896,672	5,059	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	3,896,672	38,613	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	3,896,672	124,019	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		3,896,672	9,911	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		3,896,672	16,096	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			3,896,672	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		3,896,672	9,848	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					\$ 156,575,224	\$ 69,154,917		\$ 209,961	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.)

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	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	National City Bank, Trustee		X	Finance Capital Addition	N/A		\$ 81,733	\$ 81,733			\$ 5,112	1
2												2
3												3
4								Income			(100)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 81,733	\$ 81,733			\$ 5,012	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			\$ 5,012	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	100,820	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.)			\$	97,268	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,552)	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	97,268	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.			\$	93,716	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2000	<u>94,744</u>	<u>8</u>	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			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
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																					
2001	<u>95,885</u>	<u>9</u>																						
2002	<u>90,737</u>	<u>10</u>																						
2003	<u>93,729</u>	<u>11</u>																						
2004	<u>97,268</u>	<u>12</u>																						

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-Henry COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0041814

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>03-09-326-001</u>	<u>See Attached</u>	\$ <u>97,268.50</u>	\$ <u>97,268.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>97,268.50</u>	\$ <u>97,268.50</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 & 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-Henry

0041814 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 174,000</u>	1
2					2
3	TOTALS			\$ 174,000	3

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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 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	93		1988	1988	\$ 1,748,953	\$ 50,140		\$ 50,140		\$ 789,506	4
5	1			2005	342,188						5
6											6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					112,097		112,097		682,577	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	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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	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	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	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	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)		\$ 2,905,092	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	70

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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		\$ 2,905,092	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	1
2	<u>PAINING</u>	2000	3,000						2
3	<u>PAINING FOR RESIDENTS ROOMS</u>	2000	906						3
4	<u>DOOR HARDWARE</u>	2000	730						4
5	<u>PAINING</u>	2000	3,000						5
6	<u>PAINING</u>	2000	(3,000)						6
7	<u>DRYWALL</u>	2000	7,280						7
8	<u>SMOKE DAMPERS</u>	2000	658						8
9	<u>ADDL'T COST SMOKE DAMPERS</u>	2000	73						9
10	<u>TOTAL DOORS</u>	2000	610						10
11	<u>WALLCOVERING</u>	2000	170						11
12	<u>WALLCOVERING</u>	2000	709						12
13	<u>WALLCOVERING</u>	2000	519						13
14	<u>WALLCOVERING</u>	2000	299						14
15	<u>CEILING</u>	2001	1,225						15
16	<u>CUSTOM WORKSTATION</u>	2001	2,067						16
17	<u>PAINT & WALLCOVERING</u>	2001	1,760						17
18	<u>WALLCOVERING - LOUNGE RENOVATION</u>	2001	557						18
19	<u>WINDOWS</u>	2001	855						19
20	<u>HOT WATER HEATERS</u>	2001	7,900						20
21	<u>DRAPES</u>	2001	2,980						21
22	<u>CARPET</u>	2001	29,586						22
23	<u>ADDTL COSTS FOR CARPET</u>	2001	2,260						23
24	<u>CARPET</u>	2001	500						24
25	<u>WALLCOVERING</u>	2001	516						25
26	<u>WALLCOVERING</u>	2001	90						26
27	<u>CARPENTRY - LOUNGE RENOVATION</u>	2001	6,002						27
28	<u>DRAPES, SHADES, BLINDS - LOUNGE RENOVATION</u>	2001	1,109						28
29	<u>CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION</u>	2001	10,360						29
30	<u>PAINING, WALLCOVERING - LOUNGE RENOVATION</u>	2001	9,691						30
31	<u>PLUMBING - LOUNGE RENOVATION</u>	2001	4,425						31
32	<u>CONCRETE</u>	2001	2,248						32
33	<u>CPQ SUC PK 3YR</u>	2001	932						33
34	TOTAL (lines 1 thru 33)		\$ 3,005,109	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	34

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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		\$ 3,005,109	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	1
2	<u>ROOFING</u>	2002	12,870						2
3	<u>INSTALL LIGHTING</u>	2002	2,065						3
4	<u>FLOORING,PAINTING,VWC</u>	2002	16,778						4
5	<u>ARTWORK</u>	2002	1,390						5
6	<u>AUDIT ADJ (#6) - ARTWORK</u>	2002	(1,390)						6
7	<u>ROOF</u>	2003	57,188						7
8	<u>OVERHEAD & INTEREST</u>	2003	224						8
9	<u>AUDIT ADJ (#7) - OVERHEAD & INTEREST</u>	2003	(224)						9
10	<u>ADDITIONAL ROOF COSTS</u>	2003	16,778						10
11	<u>MAIN DINING/LOUNGE VWC, FLOORING, PAINT</u>	2003	23,253						11
12	<u>MAIN DINING/LOUNGE VINYL WALL COVERING</u>	2003	5,321						12
13	<u>DOORS</u>	2003	5,757						13
14	<u>OUTDOOR SECURITY LIGHTING</u>	2003	6,525						14
15	<u>OUTDOOR SECURITY LIGHTING</u>	2003	725						15
16	<u>ASPHALT, SEAL & STRIPE PARKING LOT</u>	2003	5,865						16
17	<u>Resilient Flooring</u>	2004	22,526						17
18	<u>Automatic Door</u>	2004	4,630						18
19	<u>Electrical</u>	2004	1,440						19
20	<u>Wallcovering</u>	2004	397						20
21	<u>Vinyl Wall Covering</u>	2004	72						21
22	<u>Vinyl Wall Covering</u>	2004	162						22
23	<u>Vinyl Wall Covering</u>	2004	62						23
24	<u>Vinyl Wall Covering & Border</u>	2004	3,260						24
25	<u>Vinyl Wall Covering</u>	2004	229						25
26	<u>Credits on Wallcovering</u>	2004	(18)						26
27	<u>Cove Base</u>	2004	400						27
28	<u>Bathroom doors, locks, & Floor</u>	2003	40,831						28
29	<u>Smoke Dampers</u>	2004	1,996						29
30	<u>Smoke Dampers</u>	2004	222						30
31	<u>Flooring, VCT</u>	2004	10,420						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,244,863	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	34

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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		\$ 3,244,863	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	1
2	Parking Light Fixtures	2005	4,120						2
3	Site concrete, site preparation	2005	43,364						3
4	Field testing, Foundation testing	2005	4,234						4
5	Excavation, Paving	2005	17,775						5
6	Excavation, Paving	2005	16,609						6
7	Exit Lights	2004	1,480						7
8	Windows	2005	2,675						8
9	Painting	2005	7,200						9
10	Freight on Carpet	2005	348						10
11	General Overhead & Interest	2005	132,007						11
12	Vinyl Wall Covering, Flooring	2005	5,764						12
13	Doors	2005	5,995						13
14	Remove and Install Floor	2005	3,689						14
15	Wall covering, Carpet Pads	2005	33,481						15
16	Custom Cabinets, tops, nursing sta	2005	26,300						16
17	Electrical, emergency power system	2005	91,051						17
18	Overhead, Interest, Engineering cost	2005	24,303						18
19	Generator Installation	2005	5,886						19
20	Generator Installation	2005	5,462						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)		\$ 3,676,605	\$ 162,237		\$ 162,237	\$	\$ 1,472,083	34

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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	\$ 1,186,109	\$ 71,486	\$ 71,486	\$		\$ 934,336	71
72	Current Year Purchases	116,813						72
73	Fully Depreciated Assets							73
74	H/O Allocation			9,848	9,848			74
75	TOTALS	\$ 1,302,922	\$ 71,486	\$ 81,334	\$ 9,848		\$ 934,336	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				\$	\$	\$	\$		\$	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)	\$ 5,153,527	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,723	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,571	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,848	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,406,419	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: 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>2006</u>	\$ _____
13.	<u>2007</u>	\$ _____
14.	<u>2008</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: \$ 19,473 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			\$ _____	\$ _____	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>
--	---	--

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	453 hrs	\$ 10,073	5,544	\$ 138,606	\$ 2,423	5,997	\$ 151,102	1
2	Licensed Speech and Language Development Therapist	10a	194 hrs	4,308	1,171	29,285	7	1,365	33,600	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	302 hrs	6,706	4,944	123,593	2,466	5,246	132,765	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				97,708		97,708	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,EKG, X-Ray	10,Col 3,39				9,124			9,124	13
14	TOTAL			\$ 21,087	11,659	\$ 300,608	\$ 102,604	12,608	\$ 424,299	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-Henry# 0041814Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 662	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (71,719))	380,650		3
4	Supply Inventory (priced at)	32,904		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,321		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 415,537	\$	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	3,676,604		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,302,923		16
17	Accumulated Depreciation (book methods)	(2,406,418)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,747,109	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,162,646	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,793	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,227		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,268		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>	48,622		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 341,910	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,733		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	13,210		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 94,943	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 436,853	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,725,793	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,162,646	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,351,542	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,351,542	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,238,380	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,238,380	17
B. Transfers (Itemize):			
18	Change in Interdivision	(864,129)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (864,129)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,725,793	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Henry# 0041814Report 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	\$ 4,421,451	1
2	Discounts and Allowances for all Levels	(252,542)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,168,909	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	853,437	6
7	Oxygen	18,147	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 871,584	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	5,465	12
13	Barber and Beauty Care	17,461	13
14	Non-Patient Meals	3,613	14
15	Telephone, Television and Radio	3,771	15
16	Rental of Facility Space		16
17	Sale of Drugs	141,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,038	19
20	Radiology and X-Ray	2,924	20
21	Other Medical Services	8,458	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 188,079	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	100	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 100	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,228,672	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	650,241	31
32	Health Care	1,814,182	32
33	General Administration	951,624	33
B. Capital Expense			
34	Ownership	361,256	34
C. Ancillary Expense			
35	Special Cost Centers	212,989	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)*	\$ 3,990,292	40
41	Income before Income Taxes (line 30 minus line 40)**	1,238,380	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,238,380	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-Henry

0041814

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	1,875	2,062	\$ 58,843	\$ 28.54	1
2	Assistant Director of Nursing	2,007	2,207	40,899	18.53	2
3	Registered Nurses	16,390	18,027	352,801	19.57	3
4	Licensed Practical Nurses	12,361	13,595	230,546	16.96	4
5	CNAs & Orderlies	53,414	58,747	593,802	10.11	5
6	CNA Trainees					6
7	Licensed Therapist	883	949	21,087	22.22	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,538	3,914	34,696	8.86	10
11	Social Service Workers	3,875	4,267	58,685	13.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,316	21,248	185,389	8.73	15
16	Dishwashers					16
17	Maintenance Workers	1,347	1,482	23,758	16.03	17
18	Housekeepers	8,143	8,955	70,687	7.89	18
19	Laundry	5,183	5,702	44,854	7.87	19
20	Administrator	2,265	2,265	77,624	34.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,788	10,628	117,598	11.06	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	1,363	1,504	21,597	14.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,748	155,552	\$ 1,932,866 *	\$ 12.43	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	5,850	Line9,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)		\$ 5,850		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-Henry

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. HCA \$ 5,261
- (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 \$ 1,735
- (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? 94
- (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. \$ 34,658 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. \$ 49,967
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. \$ (3,613)
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.