

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0041806

Facility Name: Heartland Health Care Center-Galesburg

Address: 280 East Losey Street Galesburg 61401
 Number City Zip Code

County: Knox

Telephone Number: (309) 343-2166 **Fax #** (309) 343-3289

HFS ID Number: _____

Date of Initial License for Current Owners: 01/01/1964

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 **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 01/01/2006 to 12/31/2006 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 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-Galesburg# 0041806 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	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	84	TOTALS	84	30,660	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,876	10,628	10,087	22,591	8
9	SNF/PED					9
10	ICF	4,436			4,436	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,312	10,628	10,087	27,027	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.15%

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

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

YES NO

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

Date started 11/01/1981

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

YES Date 11/01/1981 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 7,799Medicare Intermediary National Government Services (formerly Administar)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	129,940	11,592	16,073	157,605	1,808	159,413		159,413		1
2	Food Purchase		169,880		169,880		169,880	(3,832)	166,048		2
3	Housekeeping	91,088	18,640	1,036	110,764		110,764		110,764		3
4	Laundry	26,024	10,307	23,106	59,437		59,437		59,437		4
5	Heat and Other Utilities			147,092	147,092	4,239	151,331	(2,155)	149,176		5
6	Maintenance	59,100	4,712	106,043	169,855		169,855		169,855		6
7	Other (specify):* Medical Waste			591	591		591		591		7
8	TOTAL General Services	306,152	215,131	293,941	815,224	6,047	821,271	(5,987)	815,284		8
	B. Health Care and Programs										
9	Medical Director			9,300	9,300		9,300		9,300		9
10	Nursing and Medical Records	1,446,617	115,516	86,923	1,649,056	2,864	1,651,920	(59,095)	1,592,825		10
10a	Therapy		2,969	622,682	625,651		625,651		625,651		10a
11	Activities	30,540	4,780	2,000	37,320		37,320	(855)	36,465		11
12	Social Services	98,574	2	1,765	100,341		100,341		100,341		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,575,731	123,267	722,670	2,421,668	2,864	2,424,532	(59,950)	2,364,582		16
	C. General Administration										
17	Administrative	62,221		256,459	318,680	(50,842)	267,838		267,838		17
18	Directors Fees										18
19	Professional Services			1,137	1,137	(156)	981	(981)			19
20	Dues, Fees, Subscriptions & Promotions			58,198	58,198		58,198	(34,077)	24,121		20
21	Clerical & General Office Expenses	155,831	48,540	(192,251)	12,120	156	12,276	238,420	250,696		21
22	Employee Benefits & Payroll Taxes			491,551	491,551	31,255	522,806		522,806		22
23	Inservice Training & Education			729	729		729		729		23
24	Travel and Seminar			6,206	6,206		6,206		6,206		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,086	79,086		79,086		79,086		26
27	Other (specify):* Personal Purch			25	25		25		25		27
28	TOTAL General Administration	218,052	48,540	701,140	967,732	(19,587)	948,145	203,362	1,151,507		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,099,935	386,938	1,717,751	4,204,624	(10,676)	4,193,948	137,425	4,331,373		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: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			280,071	280,071	10,676	290,747		290,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,276	60,276		60,276	(63)	60,213			32
33	Real Estate Taxes			66,523	66,523		66,523	(12,794)	53,729			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,889	39,889		39,889		39,889			35
36	Other (specify):*											36
37	TOTAL Ownership			446,759	446,759	10,676	457,435	(12,857)	444,578			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		358,330	84,419	442,749		442,749		442,749			39
40	Barber and Beauty Shops			9,055	9,055		9,055		9,055			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,068	46,068		46,068		46,068			42
43	Other (specify):* IV Therapy		17,040		17,040		17,040		17,040			43
44	TOTAL Special Cost Centers		375,370	139,542	514,912		514,912		514,912			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,099,935	762,308	2,304,052	5,166,295		5,166,295	124,568	5,290,863			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: 01/01/2006

Ending: 12/31/2006

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	\$ (855)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,832)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,155)	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	(63)	32		10
11	Discounts, Allowances, Rebates & Refunds	12	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	5,045	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(50,502)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(981)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	234,692	21		24
25	Fund Raising, Advertising and Promotional	(34,077)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,794)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,922)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 124,568		\$	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))	\$ 124,568		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

BHF USE ONLY						
48		49		50		51
						52

Heartland Health Care Center-Galesburg

ID# 0041806

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Customer Reimbursement	\$ (1,124)	21	1
2	Transportation Revenue	(3,768)	10	2
3	Purchase Svc - Phys Care	(4,825)	10	3
4	Donations Revenue	(205)	21	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	(9,922)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(3,832)	0	0	0	0	0	0	0	0	0	0	(3,832)	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	(2,155)	0	0	0	0	0	0	0	0	0	0	(2,155)	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	(5,987)	0	0	0	0	0	0	0	0	0	0	(5,987)	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	(59,095)	0	0	0	0	0	0	0	0	0	0	(59,095)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(855)	0	0	0	0	0	0	0	0	0	0	(855)	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	(59,950)	0	0	0	0	0	0	0	0	0	0	(59,950)	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	(981)	0	0	0	0	0	0	0	0	0	0	(981)	19
20	Fees, Subscriptions & Promotions	(34,077)	0	0	0	0	0	0	0	0	0	0	(34,077)	20
21	Clerical & General Office Expenses	238,420	0	0	0	0	0	0	0	0	0	0	238,420	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	203,362	0	0	0	0	0	0	0	0	0	0	203,362	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	137,425	0	0	0	0	0	0	0	0	0	0	137,425	29

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	32
33	Real Estate Taxes	(12,794)	0	0	0	0	0	0	0	0	0	0	(12,794)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,857)	0	(12,857)	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)	124,568	0	124,568	45									

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 256,459	HCR ManorCare, Inc	100.00%	\$ 256,459	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	12,019	Heartland Management Services	100.00%	12,019	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 268,478			\$ 268,478	\$ *

* 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: 01/01/2006 Ending: 12/31/2006

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: 01/01/2006 Ending: 2/31/2006

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 ManorCare, 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	2,604,994,312	369 Nurs Fac	\$	\$	5,054,540	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	5,054,540	1,808	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		5,054,540	971	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		5,054,540	3,268	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			5,054,540	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	5,054,540	2,864	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,206,110	32,327,667	5,054,540	79,953	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	5,054,540	125,664	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,198		5,054,540	16,412	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,678		5,054,540	14,843	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			5,054,540	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		5,054,540	10,676	12
13										13
14	32	Interest				4,662,634				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 156,594,107	\$ 76,712,615		\$ 256,459	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								Income			(63)	3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 964,387	\$ 964,387			\$ 60,213	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			\$ 60,213	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>99-10-427-018</u>	<u>See Attached</u>	\$ <u>33,261.73</u>	\$ <u>33,261.73</u>
2. <u>99-10-427-018</u>	<u>See Attached</u>	\$ <u>33,261.73</u>	\$ <u>33,261.73</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>66,523.46</u>	\$ <u>66,523.46</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,388 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 & 2003</u>	<u>\$ 121,935</u>	1
2	<u>Facility</u>		<u>2006</u>	<u>47,025</u>	2
3	TOTALS			\$ 168,960	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	\$ 36,981		\$ 36,981		\$ 474,475	4
5	7			2003	570,110						5
6	7/1/06 Capital Rate Adj #1			2003	81,936						6
7				2005	637,826						7
8	7/1/06 Capital Rate Adj #14			2005	125,742						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					147,035		147,035		1,220,781	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											

*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:

01/01/2006 Ending: 12/31/2006

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	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45 (1996)	1996	(627)						46
47	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580						47
48	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								48
49	vinyl flooring								49
50	Building Improvements : Doors	1997	10,728						50
51	Building Improvements : Electrical composite, automatic doors,	1997	38,947						51
52	metal doors, fire alarm system								52
53	Building Improvements : Capalo	1997	2,500						53
54	Building Improvements : Generator	1997	7,743						54
55	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						55
56	Building Improvements : Onan Genator	1997	17,482						56
57	Building Improvements : Soffits, gutters & trim	1997	9,962						57
58	Building Improvements : Generator	1997	24,885						58
59	Building Improvements - HVAC	1997	42,499						59
60	Land Improvements - Sidewald	1998	7,988						60
61	Building Improvements - Fire Prevention System	1998	35,013						61
62	Sidewalk	1999	7,988						62
63	Sidewalk	1999	900						63
64	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	1999	(900)						64
65	Overhead from const	1999	2,681						65
66	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	1999	(2,681)						66
67	Power control wiring for ne	1999	2,392						67
68	Sprinkler system upgrade	1999	19,107						68
69	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	1999	(1,740)						69
70	TOTAL (lines 4 thru 69)		\$ 3,084,150	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	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:

01/01/2006 Ending: 12/31/2006

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		\$ 3,084,150	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	1
2	Air compressor	1999	598						2
3	Laundry room floor	1999	1,800						3
4	Sprinkler upgrade	1999	23,940						4
5	Fire sprinkler system	1999	2,971						5
6	Boiler	1999	33,600						6
7	HVAC upgrade	1999	2,420						7
8	Building improvements	1999	1,200						8
9	SMOKING HUT	2000	4,950						9
10	CONCRETE FOR SMOKE HUT	2000	350						10
11	CABINETRY	2000	3,690						11
12	ELECTRICAL	2000	20,205						12
13	ADDT'L COST SMOKING HUT	2000	645						13
14	ELECTRICAL	2000	10,880						14
15	ELECTRICAL	2000	3,454						15
16	HVAC	2000	21,662						16
17	ELECTRICAL/NEW OFFICE	2000	860						17
18	CABINETS	2000	1,369						18
19	HVAC	2000	1,736						19
20	HVAC	2000	193						20
21	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						21
22	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2000	(15,146)						22
23	AIR / HUMIDIFIER COIL	2001	5,233						23
24	CANOPY	2001	1,200						24
25	CONCRETE PATIO	2001	5,500						25
26	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						26
27	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2001	(6,839)						27
28	VWC	2002	1,172						28
29	Carpet	2002	1,534						29
30	Border	2002	111						30
31	Border	2002	125						31
32	Brick Work	2002	5,787						32
33	Addition Cost Brick Work	2002	643						33
34	TOTAL (lines 1 thru 33)		\$ 3,333,631	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	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:

01/01/2006 Ending: 12/31/2006

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		\$ 3,333,631	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	1
2	Artwork	2002	2,219						2
3	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2002	(2,219)						3
4	Paint & Wallcovering	2002	2,810						4
5	Paint & Wallcovering	2002	3,122						5
6	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						6
7	Overhead & Interest	2003	431						7
8	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)						8
9	Paint, Flooring & VWC	2003	12,182						9
10	Paint, Flooring & VWC	2003	1,354						10
11	Freight on Carpet	2003	56						11
12	Carpet, Wallcovering and Corner Guards	2003	12,197						12
13	Developers Costs - Architect & Engineering Fees	2003	96,312						13
14	7/1/06 Capital Rate Adj #4	2003	(10,839)						14
15	7/1/06 Capital Rate Adj #5	2003	(17,967)						15
16	Developers Costs - T&E, Reprod.,Permit & Plan Review Fees	2003	15,798						16
17	7/1/06 Capital Rate Adj #6	2003	(5,436)						17
18	Developers Costs - Overhead	2003	152,775						18
19	7/1/06 Capital Rate Adj #7	2003	(152,775)						19
20	Developers Costs - Interest	2003	13,748						20
21	7/1/06 Capital Rate Adj #8	2003	(13,748)						21
22	Millwork	2003	4,664						22
23	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						23
24	7/1/06 Capital Rate Adj #2	2003	(6,851)						24
25	Site Work/Preparation	2003	74,492						25
26	7/1/06 Capital Rate Adj #3	2003	(74,492)						26
27	CONSULTING SERVICES-PHASE 2 ADDITION	2003	3,200						27
28	ARCHITECTURAL SERVICES	2003	9,117						28
29	ENGINEERING COST-CENTRAL BATH RENOV	2004	4,013						29
30	ENGINEERING COST-CENTRAL BATH RENOV	2004	6,479						30
31	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	723						31
32	ARCHITECTURAL COST-CENTRAL BATH RENOV	2004	180						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,506,529	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	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:

01/01/2006 Ending: 12/31/2006

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		\$ 3,506,529	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	1
2	ENGINEERING COST-CENTRAL BATH RENOV	2004	450						2
3	VINYL WALL COVERING	2004	266						3
4	BORDER	2004	948						4
5	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	2,986						5
6	BORDER FOR BATH	2004	85						6
7	ENGINEERING COST-CENTRAL BATH RENOV	2004	2,794						7
8	CARPET & COVE BASE	2004	6,273						8
9	VINYL WALL COVERING	2004	8,199						9
10	GAZEBO	2004	6,389						10
11	MATERIAL & SVCS-NURSING STA & BATH	2004	93,206						11
12	VINYL WALL COVERING	2005	497						12
13	GENERAL CONTRACTOR	2005	117,042						13
14	7/1/06 Capital Rate Adj #9	2005	(117,042)						14
15	SOIL TESTING	2005	1,790						15
16	7/1/06 Capital Rate Adj #10	2005	(1,790)						16
17	GAS SERVICE	2005	321						17
18	7/1/06 Capital Rate Adj #11	2005	(321)						18
19	SOIL TESTING	2005	3,370						19
20	7/1/06 Capital Rate Adj #12	2005	(3,370)						20
21	CONCRETE TESTING	2005	2,555						21
22	7/1/06 Capital Rate Adj #13	2005	(2,555)						22
23	GENERAL OVERHEAD	2005	8,273						23
24	7/1/06 Capital Rate Adj #15	2005	(8,273)						24
25	INTEREST ON CONSTRUCTION	2005	426						25
26	7/1/06 Capital Rate Adj #16	2005	(426)						26
27	CARPETING & PADS	2005	708						27
28	WALL COVERING	2005	4,135						28
29	CARPENTRY	2005	68,875						29
30	DRYWALL/STUDS	2005	1,500						30
31	DOORS/FRAMES	2005	1,125						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,704,964	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	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:

01/01/2006 Ending: 12/31/2006

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 12D, Carried Forward		\$ 3,704,964	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	1
2	ARCHITECT & ENGINEER COST	2005	59,040						2
3	ARCHITECT & ENGINEER COST	2005	8,988						3
4	ENGINEERING - CIVIL	2005	9,080						4
5	ENGINEERING - ELECTRIC	2005	600						5
6	LANDSCAPE DESIGN CONTRACTOR	2005	12,705						6
7	OVERHEAD	2005	106,428						7
8	7/1/06 Capital Rate Adj #18	2005	(106,428)						8
9	PERMIT FEES	2005	2,825						9
10	PLAN REVIEWS	2005	8,271						10
11	7/1/06 Capital Rate Adj #19	2005	(8,271)						11
12	INTEREST ON CONSTRUCTION	2005	16,467						12
13	7/1/06 Capital Rate Adj #20	2005	(16,467)						13
14	CARPETING AND PADS	2005	2,835						14
15	WALL COVERING	2005	9,095						15
16	CORNER GUARDS	2006	225						16
17	FIRE PROTECTION PIPING	2006	600						17
18	BASIC ELECTRICAL	2006	490						18
19	WALLCOVERINGS	2006	1,215						19
20	3 SETS OF DOORS	2006	4,226						20
21	INSTALL GUTTERS/WINDOWS	2006	14,500						21
22	VINYL WALL COVERING	2006	150						22
23	GUTTERS	2006	2,025						23
24	FLOORING-KITCHEN STORAGE	2006	6,278						24
25	EXPAND FREEZER & COOLER	2006	30,957						25
26	DOOR	2006	3,041						26
27	SIDEWALKS	2006	6,879						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,880,718	\$ 184,016		\$ 184,016	\$	\$ 1,695,256	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: 01/01/2006 Ending: 12/31/2006

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	\$ 1,298,536	\$ 96,055	\$ 96,055	\$		\$ 981,958	71
72	Current Year Purchases	139,398						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			10,676	10,676			74
75	TOTALS	\$ 1,437,934	\$ 96,055	\$ 106,731	\$ 10,676		\$ 981,958	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)	\$ 5,508,330	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 280,071	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 290,747	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,676	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,697,932	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 39,889 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>
--	---	--

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	hrs	\$	10,408	\$ 260,209	\$ 1,447	10,408	\$ 261,656	1
2	Licensed Speech and Language Development Therapist	10a	hrs		4,259	106,475	231	4,259	106,706	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		10,191	254,775	1,291	10,191	256,066	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				358,330		358,330	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-X-Ray, Lab	10,Col 3, 39				85,642			85,642	13
14	TOTAL			\$	24,858	\$ 707,101	\$ 361,299	24,858	\$ 1,068,400	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: 01/01/2006

Ending:

12/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2006

(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	\$ 35,306	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (115,389))	781,045		3
4	Supply Inventory (priced at)	27,292		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,046		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 844,689	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,960		13
14	Buildings, at Historical Cost	3,880,717		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,458,656		16
17	Accumulated Depreciation (book methods)	(2,697,932)		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)	\$ 2,810,401	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,655,090	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,913	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,799		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,523		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 Assets</u>	63,645		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 366,880	\$	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)	\$ 1,331,267	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,323,823	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,655,090	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,688,305	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,688,305	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	318,128	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)	\$ 318,128	17
B. Transfers (Itemize):			
18	Change in Interdivision	(682,610)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (682,610)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,323,823	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	\$ 4,108,345	1
2	Discounts and Allowances for all Levels	(285,515)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,822,830	3
B. Ancillary Revenue			
4	Day Care	855	4
5	Other Care for Outpatients		5
6	Therapy	1,251,590	6
7	Oxygen	14,975	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,267,420	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	815	12
13	Barber and Beauty Care	10,558	13
14	Non-Patient Meals	3,043	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	317,394	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,380	19
20	Radiology and X-Ray	16,712	20
21	Other Medical Services	9,220	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 394,122	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	63	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Disc	(12)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (12)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,484,423	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	815,224	31
32	Health Care	2,421,668	32
33	General Administration	967,732	33
B. Capital Expense			
34	Ownership	446,759	34
C. Ancillary Expense			
35	Special Cost Centers	514,912	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)*	\$ 5,166,295	40
41	Income before Income Taxes (line 30 minus line 40)**	318,128	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 318,128	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: 01/01/2006

Ending:

12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,271	\$ 60,480	\$ 26.63	1
2	Assistant Director of Nursing	3,890	4,236	102,152	24.12	2
3	Registered Nurses	13,016	14,172	316,350	22.32	3
4	Licensed Practical Nurses	17,124	18,645	310,593	16.66	4
5	CNAs & Orderlies	58,089	63,249	619,423	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,443	2,663	30,540	11.47	10
11	Social Service Workers	4,928	5,333	98,574	18.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,910	16,232	129,940	8.01	15
16	Dishwashers					16
17	Maintenance Workers	3,982	4,341	59,100	13.61	17
18	Housekeepers	9,497	10,339	91,088	8.81	18
19	Laundry	2,911	3,170	26,024	8.21	19
20	Administrator	2,004	2,004	62,221	31.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,581	10,519	155,831	14.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,346	3,640	37,619	10.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,807	160,814	\$ 2,099,935 *	\$ 13.06	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	9,300	Ln 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)		\$ 9,300		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

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 \$ 2,495 ALLIANCE \$ 2,322
- (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 \$ 3,087
- (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. \$ 37,912 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. \$ 46,068
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. \$ (3,043)
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.