		FOR BHF USE					

LL1

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: 0041814

Facility Name: Heartland Health Care Center-Henry

Address: 1650 Indian Town Road (Number) Henry (City) 61537 (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:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/2006 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) Barry Lazarus
	(Title) Vice President of Reimbursement
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,179	7,456	8,464	19,099	8
9	SNF/PED					9
10	ICF	954	8,901	12	9,867	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,133	16,357	8,476	28,966	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.42%

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/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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 66 and days of care provided 6,793

Medicare Intermediary National Government Services (formerly Administar)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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-Henry # 0041814 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,232	13,445	8,631	218,308	1,602	219,910		219,910			1
2	Food Purchase		142,185		142,185		142,185	(9,134)	133,051			2
3	Housekeeping	66,136	12,868	383	79,387		79,387		79,387			3
4	Laundry	48,510	9,848		58,358		58,358		58,358			4
5	Heat and Other Utilities			107,936	107,936	3,755	111,691	(5,075)	106,616			5
6	Maintenance	37,143	12,551	50,767	100,461		100,461		100,461			6
7	Other (specify):* Medical Waste			622	622		622		622			7
8	TOTAL General Services	348,021	190,897	168,339	707,257	5,357	712,614	(14,209)	698,405			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,384,628	91,901	22,841	1,499,370	2,538	1,501,908	(8,907)	1,493,001			10
10a	Therapy		10,172	428,949	439,121		439,121		439,121			10a
11	Activities	66,718	8,764	4,156	79,638		79,638		79,638			11
12	Social Services	68,094	851	1,410	70,355		70,355		70,355			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,519,440	111,688	470,356	2,101,484	2,538	2,104,022	(8,907)	2,095,115			16
	C. General Administration											
17	Administrative	77,794		227,249	305,043	(45,049)	259,994		259,994			17
18	Directors Fees											18
19	Professional Services			7,907	7,907	(34)	7,873	(7,873)				19
20	Dues, Fees, Subscriptions & Promotions			57,081	57,081		57,081	(41,010)	16,071			20
21	Clerical & General Office Expenses	101,224	45,175	33,048	179,447	34	179,481	(26,802)	152,679			21
22	Employee Benefits & Payroll Taxes			416,502	416,502	27,694	444,196		444,196			22
23	Inservice Training & Education			1,557	1,557		1,557		1,557			23
24	Travel and Seminar			6,233	6,233		6,233		6,233			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,207	93,207		93,207		93,207			26
27	Other (specify):* Personal Purchase			926	926		926	(926)				27
28	TOTAL General Administration	179,018	45,175	843,710	1,067,903	(17,355)	1,050,548	(76,611)	973,937			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,046,479	347,760	1,482,405	3,876,644	(9,460)	3,867,184	(99,727)	3,767,457			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: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			230,186	230,186	9,460	239,646		239,646			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,112	5,112		5,112		5,112			32
33	Real Estate Taxes			92,135	92,135		92,135	(1,581)	90,554			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			61,239	61,239		61,239		61,239			35
36	Other (specify):*											36
37	TOTAL Ownership			388,672	388,672	9,460	398,132	(1,581)	396,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,149	20,111	218,260		218,260		218,260			39
40	Barber and Beauty Shops			10,839	10,839		10,839		10,839			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,324	51,324		51,324		51,324			42
43	Other (specify):*		42,805		42,805		42,805		42,805			43
44	TOTAL Special Cost Centers		240,954	82,274	323,228		323,228		323,228			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,046,479	588,714	1,953,351	4,588,544		4,588,544	(101,308)	4,487,236			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: 01/01/2006 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,075)	5		5
6	Rented Facility Space	(2,700)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	1,935	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,373)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(205)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,873)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,504)	21		24
25	Fund Raising, Advertising and Promotional	(41,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,581)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,790)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,308)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (101,308)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Henry

ID# 0041814

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue	$ (4,682)	10	1
2	Purchase Svc - Phys Care	(1,852)	10	2
3	Personal Purchases	(926)	27	3
4	Donations Revenue	(2,330)	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	(9,790)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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	(9,134)	0	0	0	0	0	0	0	0	0	0	(9,134)	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	(5,075)	0	0	0	0	0	0	0	0	0	0	(5,075)	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**	(14,209)	0	0	0	0	0	0	0	0	0	0	(14,209)	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	(8,907)	0	0	0	0	0	0	0	0	0	0	(8,907)	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**	(8,907)	0	0	0	0	0	0	0	0	0	0	(8,907)	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	(7,873)	0	0	0	0	0	0	0	0	0	0	(7,873)	19
20	Fees, Subscriptions & Promotions	(41,010)	0	0	0	0	0	0	0	0	0	0	(41,010)	20
21	Clerical & General Office Expenses	(26,802)	0	0	0	0	0	0	0	0	0	0	(26,802)	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):*	(926)	0	0	0	0	0	0	0	0	0	0	(926)	27
28	**TOTAL General Administration**	(76,611)	0	0	0	0	0	0	0	0	0	0	(76,611)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,727)	0	0	0	0	0	0	0	0	0	0	(99,727)	29

STATE OF ILLINOIS

Summary B

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

	Capital Expense D. Ownership	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)	
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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,581)	0	0	0	0	0	0	0	0	0	0	(1,581)	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**	(1,581)	0	0	0	0	0	0	0	0	0	0	(1,581)	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)**	(101,308)	0	0	0	0	0	0	0	0	0	0	(101,308)	45

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 227,249	HCR Manor Care, Inc	100.00%	$ 227,249	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	7,724	Heartland Management Services	100.00%	7,724		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 234,973			$ 234,973	$ *	14

* 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: 01/01/2006 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 01/01/2006 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	$	$	4,478,842	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	4,478,842	1,602	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		4,478,842	860	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		4,478,842	2,895	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			4,478,842	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	4,478,842	2,538	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,207,110	32,327,667	4,478,842	70,849	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	4,478,842	111,351	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,198		4,478,842	14,542	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,678		4,478,842	13,152	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			4,478,842	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		4,478,842	9,460	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					$ 156,595,107	$ 76,712,615		$ 227,249	25

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	National City Bank, Trustee		X	Finance Capital Addition	N/A		$ 81,733	$ 81,733			$ 5,112	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 81,733	$ 81,733			$ 5,112	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			$ 5,112	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.)

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	$ 93,716	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.)	$ 92,135	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,581)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 92,135	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.	$ 90,554	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2001	95,885	8
2002	90,737	9
2003	93,729	10
2004	97,268	11
2005	92,135	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-09-326-001	See Attached	$ 92,134.88	$ 92,134.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,134.88	$ 92,134.88

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 comsidered 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-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	$ 174,000	1
2					2
3	TOTALS			$ 174,000	3

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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 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	$ 53,363		$ 53,363	$	$ 842,868	4
5	1			2005	342,188						5
6	7/1/06 CAPITAL RATE ADJUST #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					97,838		97,838		780,414	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	7/1/03 Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	THERMOSTATIC MIXING VALVE	1998	$ 15,929	$		$	$	$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,948,456	$ 151,201		$ 151,201	$	$ 1,623,282	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: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,948,456	$ 151,201		$ 151,201	$	$ 1,623,282	1
2	PAINTING	2000	3,000						2
3	PAINTING FOR RESIDENTS ROOMS	2000	906						3
4	DOOR HARDWARE	2000	730						4
5	PAINTING	2000	3,000						5
6	PAINTING	2000	(3,000)						6
7	DRYWALL	2000	7,280						7
8	SMOKE DAMPERS	2000	658						8
9	ADDL'T COST SMOKE DAMPERS	2000	73						9
10	TOTAL DOORS	2000	610						10
11	WALLCOVERING	2000	170						11
12	WALLCOVERING	2000	709						12
13	WALLCOVERING	2000	519						13
14	WALLCOVERING	2000	299						14
15									15
16	CEILING	2001	1,225						16
17	CUSTOM WORKSTATION	2001	2,067						17
18	PAINT & WALLCOVERING	2001	1,760						18
19	WALLCOVERING - LOUNGE RENOVATION	2001	557						19
20	WINDOWS	2001	855						20
21	HOT WATER HEATERS	2001	7,900						21
22	DRAPES	2001	2,980						22
23	CARPET	2001	29,586						23
24	ADDTL COSTS FOR CARPET	2001	2,260						24
25	CARPET	2001	500						25
26	WALLCOVERING	2001	516						26
27	WALLCOVERING	2001	90						27
28	CARPENTRY - LOUNGE RENOVATION	2001	6,002						28
29	DRAPES, SHADES, BLINDS - LOUNGE RENOVATION	2001	1,109						29
30	CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION	2001	10,360						30
31	PAINTING, WALLCOVERING - LOUNGE RENOVATION	2001	9,691						31
32	PLUMBING - LOUNGE RENOVATION	2001	4,425						32
33	CONCRETE	2001	2,248						33
34	TOTAL (lines 1 thru 33)		$ 3,047,541	$ 151,201		$ 151,201	$	$ 1,623,282	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: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,047,541	$ 151,201		$ 151,201	$	$ 1,623,282	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,268,248	$ 151,201		$ 151,201	$	$ 1,623,282	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: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,268,248	$ 151,201		$ 151,201	$	$ 1,623,282	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,528,481	$ 151,201		$ 151,201	$	$ 1,623,282	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: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,528,481	$ 151,201		$ 151,201	$	$ 1,623,282	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,578,784	$ 151,201		$ 151,201	$	$ 1,623,282	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: 01/01/2006 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	$ 1,302,922	$ 78,986	$ 78,986	$		$ 1,013,321	71
72	Current Year Purchases	82,012						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			9,460	9,460			74
75	TOTALS	$ 1,384,934	$ 78,986	$ 88,446	$ 9,460		$ 1,013,321	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)	$ 5,137,718	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 230,187	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 239,647	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,460	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,636,603	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.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

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	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 61,239 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.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

(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.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	7,511	$ 187,773	$ 5,783	7,511	$ 193,556	1
2	Licensed Speech and Language Development Therapist	10a	hrs		917	22,919		917	22,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		8,730	218,257	4,389	8,730	222,646	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				198,145		198,145	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S Lab, X-Ray	10, Col 3, 39			20,111		4	20,111	4	13
14	TOTAL			$	37,269	$ 428,949	$ 208,321	37,269	$ 637,270	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 # 0041814 Report 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	$ 27,135	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (93,077))	651,750		3
4	Supply Inventory (priced at)	34,447		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,078		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 714,410	$	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	3,578,783		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,384,934		16
17	Accumulated Depreciation (book methods)	(2,636,604)		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)**	$ 2,501,113	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,215,523	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 39,501	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,776		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,135		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		43,661		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 370,073	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,733		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	26,839		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 108,572	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 478,645	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,736,878	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,215,523	$	48

*(See instructions.)

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,725,793	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,725,793	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,366,492	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)**	$ 1,366,492	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(1,355,407)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,355,407)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,736,878	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,795,184	1
2	Discounts and Allowances for all Levels	(273,816)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,521,368	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,189,822	6
7	Oxygen	11,520	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,201,342	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	5,614	12
13	Barber and Beauty Care	16,076	13
14	Non-Patient Meals	3,630	14
15	Telephone, Television and Radio	5,075	15
16	Rental of Facility Space	2,700	16
17	Sale of Drugs	181,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,182	19
20	Radiology and X-Ray	2,418	20
21	Other Medical Services	6,059	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 232,328	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	Purchase Disc	(2)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,955,036	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	707,257	31
32	Health Care	2,101,484	32
33	General Administration	1,067,903	33
	B. Capital Expense		
34	Ownership	388,672	34
	C. Ancillary Expense		
35	Special Cost Centers	323,228	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)***	$ 4,588,544	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,366,492	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,366,492	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: 01/01/2006 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	2,020	2,209	$ 65,986	$ 29.87	1
2	Assistant Director of Nursing	2,096	2,292	44,282	19.32	2
3	Registered Nurses	16,006	17,502	354,334	20.25	3
4	Licensed Practical Nurses	14,166	15,490	270,283	17.45	4
5	CNAs & Orderlies	56,288	61,548	626,604	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,373	8,076	66,517	8.24	10
11	Social Service Workers	4,491	4,900	68,094	13.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,228	22,163	196,433	8.86	15
16	Dishwashers					16
17	Maintenance Workers	2,258	2,478	37,143	14.99	17
18	Housekeepers	7,328	8,033	66,136	8.23	18
19	Laundry	5,564	6,098	48,510	7.96	19
20	Administrator	2,175	2,175	77,794	35.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,530	7,789	101,224	13.00	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	1,417	1,552	23,139	14.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,940	162,305	$ 2,046,479 *	$ 12.61	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	13,000	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)		$ 13,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan M Legner	Administrator	0	$ 77,794
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,794

B. Administrative - Other

Description	Amount
Home Office	$ 227,249
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 227,249

C. Professional Services

Vendor/Payee	Type	Amount
Michael T Mahoney, LTD	Legal Fees	$ 1,260
Holland & Knight LLP	Legal Fees	6,613
Misc Vendors	Accounting Fees	34
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 7,907

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,043
Unemployment Compensation Insurance	44,472
FICA Taxes	146,977
Employee Health Insurance	181,844
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,401
Payroll Overhead Allocated	0
401K / SMSP	16,430
Employee Uniforms	2,335
Home Office Allocation	27,694
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,196

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,285
Advertising: Employee Recruitment	3,289
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 217	4,341
Dues / Subscriptions	814
Association Dues	5,652
Advertising	40,700
Less: Non-Allowable Association Dues	(3,421)
Less: Public Relations Expense	( )
Non-allowable advertising	(37,589)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,071

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,233
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,233

**See instructions.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Heartland Health Care Center-Henry** **# 0041814** **Report Period Beginning: 01/01/2006 Ending: 12/31/2006**

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 $3,218 Alliance $2,435**

(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 $3,421**

(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?

(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. $ **39,673** 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. $ **51,324**
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. $ **(3,630)**

(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 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.