

		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: 0041822

Facility Name: Heartland Health Care Center-Macomb

Address: 8 Doctors Lane Macomb 61455
 Number City Zip Code

County: Mc Donough

Telephone Number: (309) 833-5555 **Fax #** (309) 833-3749

HFS ID Number: 344402510009

Date of Initial License for Current Owners: 1966

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) () _____	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-Macomb# 0041822 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	<u>80</u>	Skilled (SNF)	<u>80</u>	<u>29,200</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>13,002</u>	<u>8,587</u>	<u>21,589</u>	8
9	SNF/PED					9
10	ICF	<u>4,178</u>			<u>4,178</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,178</u>	<u>13,002</u>	<u>8,587</u>	<u>25,767</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.24%

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

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

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

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

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

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

YES NO

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

YES NO

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

Date started 04/01/1989

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

YES Date 04/01/1989 NO

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

YES NO If YES, enter number of beds certified 80 and days of care provided 7,793Medicare 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: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Heartland Health Care Center-Maccomb # 0041822 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	170,761	14,422	7,455	192,638	1,474	194,112		194,112			1
2	Food Purchase		135,048		135,048		135,048	(29,307)	105,741			2
3	Housekeeping	57,643	10,871	103	68,617		68,617		68,617			3
4	Laundry	51,570	9,005	302	60,877		60,877		60,877			4
5	Heat and Other Utilities			86,749	86,749	3,454	90,203	(2,826)	87,377			5
6	Maintenance	37,816	10,083	50,378	98,277		98,277		98,277			6
7	Other (specify):* Medical Waste			544	544		544		544			7
8	TOTAL General Services	317,790	179,429	145,531	642,750	4,928	647,678	(32,133)	615,545			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	1,247,652	114,206	16,635	1,378,493	2,335	1,380,828	(3,157)	1,377,671			10
10a	Therapy	317	7,418	365,195	372,930		372,930		372,930			10a
11	Activities	75,467	4,386	1,840	81,693		81,693		81,693			11
12	Social Services	70,992	42	1,524	72,558		72,558		72,558			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,394,428	126,052	390,594	1,911,074	2,335	1,913,409	(3,157)	1,910,252			16
	C. General Administration											
17	Administrative	69,775		209,030	278,805	(41,439)	237,366		237,366			17
18	Directors Fees											18
19	Professional Services			675	675	(238)	437	(437)				19
20	Dues, Fees, Subscriptions & Promotions			64,843	64,843		64,843	(41,645)	23,198			20
21	Clerical & General Office Expenses	104,858	47,853	23,468	176,179	238	176,417	(9,670)	166,747			21
22	Employee Benefits & Payroll Taxes			423,102	423,102	25,475	448,577		448,577			22
23	Inservice Training & Education			5,761	5,761		5,761		5,761			23
24	Travel and Seminar			9,190	9,190		9,190		9,190			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,050	81,050		81,050		81,050			26
27	Other (specify):* Personal Purch							167	167			27
28	TOTAL General Administration	174,633	47,853	817,119	1,039,605	(15,964)	1,023,641	(51,585)	972,056			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,886,851	353,334	1,353,244	3,593,429	(8,701)	3,584,728	(86,875)	3,497,853			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-Macomb #0041822 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			240,777	240,777	8,701	249,478	249,478			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			36,336	36,336		36,336	(339)	35,997		32
33	Real Estate Taxes			54,174	54,174		54,174	(12,871)	41,303		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			27,084	27,084		27,084		27,084		35
36	Other (specify):* <i>G/L Assets</i>			1,838	1,838		1,838	(1,838)			36
37	TOTAL Ownership			360,209	360,209	8,701	368,910	(15,048)	353,862		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		145,802	93,458	239,260		239,260		239,260		39
40	Barber and Beauty Shops		25	7,497	7,522		7,522		7,522		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			44,197	44,197		44,197		44,197		42
43	Other (specify):* <i>IV Therapy</i>		13,947		13,947		13,947		13,947		43
44	TOTAL Special Cost Centers		159,774	145,152	304,926		304,926		304,926		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,886,851	513,108	1,858,605	4,258,564		4,258,564	(101,923)	4,156,641		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-Macomb

0041822

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(29,307)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,826)	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	(339)	32		10
11	Discounts, Allowances, Rebates & Refunds	1	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	4,147	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,157)	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	(437)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,348)	21		24
25	Fund Raising, Advertising and Promotional	(41,645)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,871)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,141)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (101,923)		\$	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))	\$ (101,923)		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		52

Heartland Health Care Center-Macomb

ID# 0041822

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	G/L Assets	\$ (1,838)	36	1
2	Customer Reimbursement	(345)	21	2
3	Personal Purchases	167	27	3
4	Donations Revenue	(2,125)	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	(4,141)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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	(29,307)	0	0	0	0	0	0	0	0	0	0	(29,307)	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	(2,826)	0	0	0	0	0	0	0	0	0	0	(2,826)	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	(32,133)	0	0	0	0	0	0	0	0	0	0	(32,133)	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	(3,157)	0	0	0	0	0	0	0	0	0	0	(3,157)	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	(3,157)	0	0	0	0	0	0	0	0	0	0	(3,157)	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	(437)	0	0	0	0	0	0	0	0	0	0	(437)	19
20	Fees, Subscriptions & Promotions	(41,645)	0	0	0	0	0	0	0	0	0	0	(41,645)	20
21	Clerical & General Office Expenses	(9,670)	0	0	0	0	0	0	0	0	0	0	(9,670)	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):*	167	0	0	0	0	0	0	0	0	0	0	167	27
28	TOTAL General Administration	(51,585)	0	0	0	0	0	0	0	0	0	0	(51,585)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(86,875)	0	0	0	0	0	0	0	0	0	0	(86,875)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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	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	(339)	0	0	0	0	0	0	0	0	0	0	(339)	32
33	Real Estate Taxes	(12,871)	0	0	0	0	0	0	0	0	0	0	(12,871)	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):*	(1,838)	0	0	0	0	0	0	0	0	0	0	(1,838)	36
37	TOTAL Ownership	(15,048)	0	(15,048)	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)	(101,923)	0	(101,923)	45									

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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	\$ 209,030	HCR Manor Care, Inc	100.00%	\$ 209,030	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	8,072	Heartland Management Services	100.00%	8,072	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 217,102			\$ 217,102	\$ *

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

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 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-Macomb # 0041822 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 Manor Care, Inc
 Street Address 333 North Summit St
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5494

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	\$	\$	4,119,774	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	4,119,774	1,474	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		4,119,774	791	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		4,119,774	2,663	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			4,119,774	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	4,119,774	2,335	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,206,110	32,327,667	4,119,774	65,167	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	4,119,774	102,424	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,198		4,119,774	13,377	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,678		4,119,774	12,098	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			4,119,774	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		4,119,774	8,701	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		\$ 209,030	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**					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 Additions			\$ 581,402	\$ 581,402			\$ 36,336	1					
2												2					
3												3					
4								Income			(339)	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 581,402	\$ 581,402			\$ 35,997	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 581,402	\$ 581,402			\$ 35,997	15					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 report.		\$ 67,045	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.)		\$ 54,174	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ (12,871)	3																								
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 54,174	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.		\$ 41,303	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>41,505</td><td>8</td></tr> <tr><td>2002</td><td>41,532</td><td>9</td></tr> <tr><td>2003</td><td>41,178</td><td>10</td></tr> <tr><td>2004</td><td>53,921</td><td>11</td></tr> <tr><td>2005</td><td>54,174</td><td>12</td></tr> </table>	2001	41,505	8	2002	41,532	9	2003	41,178	10	2004	53,921	11	2005	54,174	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2001	41,505	8																									
2002	41,532	9																									
2003	41,178	10																									
2004	53,921	11																									
2005	54,174	12																									
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										

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-Macomb COUNTY Mc Donough

FACILITY IDPH LICENSE NUMBER 0041822

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>11-300-953-00</u>	<u>See Attached</u>	\$ <u>53,046.46</u>	\$ <u>53,046.46</u>
2. <u>11-300-961-00</u>	<u>See Attached</u>	\$ <u>1,127.60</u>	\$ <u>1,127.60</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>54,174.06</u>	\$ <u>54,174.06</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-Macomb

0041822 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,692 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>\$ 105,511</u>	<u>1</u>
2			<u>2005</u>	<u>734</u>	<u>2</u>
3	TOTALS			\$ 106,245	3

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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	58		1983	1983	\$ 824,586	\$ 62,539		\$ 62,539	\$	\$ 921,964	4
5	6			2001	404,817						5
6	AUDIT ADJ 7/1/03 (#1)			2001	(55,875)						6
7	16			2003	726,962						7
8	AUDIT ADJ 7/1/06 (#17)			2003	56,765						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					95,941		95,941		1,138,079	9
10	Land Improvements			1983	19,035						10
11	Land Improvements - Audit Adj 7/1/03 (#7) - Chg Yr			1983	300						11
12	Building Improvements			1984	15,076						12
13	Building Improvements			1985	20,813						13
14	Building Improvements			1986	42,783						14
15	Land Improvements			1986	3,741						15
16	Adjust HGCC Purchase			1986	(60,000)						16
17	Audit Adj 7/1/03 (#2) - Pg 12, Line 16			1986	60,000						17
18	Building Improvements			1987	70,097						18
19	Interior Renovation			1987	490						19
20	Audit Adj 7/1/03 (#8) - Pg 12, Line 19			1987	(490)						20
21	Building Improvements			1988	2,068						21
22	Water Heater			1988	732						22
23	Audit Adj 7/1/03 (#3) - Pg 12 Line 22			1988	(732)						23
24	Repair Valve			1988	1,336						24
25	Audit Adj 7/1/03 (#4) - Pg 12 Line 24			1988	(1,336)						25
26	Light Fix-Over Bed			1988	3,770						26
27	Audit Adj 7/1/03 (#5) - Pg 12 Line 26			1988	(3,770)						27
28	Land Improvements			1989	1,614						28
29	Building Improvements			1989	25,315						29
30	Storage Shed			1990	4,980						30
31	Audit Adj 7/1/03 (#6) - Pg 12 Line 30			1990	(4,980)						31
32	Land Improvements			1990	950						32
33	Building Improvements			1990	11,382						33
34	Building (Bldg)			1990	3,186						34
35	Audit Adj 7/1/03 (#9) - Pg 12, Line 34			1990	(3,186)						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-Macomb

0041822

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	Building Improvements	1991	\$ 5,547	\$		\$	\$	\$	37
38	Building Improvements	1992	10,800						38
39	Land Improvements	1993	23,517						39
40	Building Improvements	1993	13,585						40
41	Building Improvements	1994	51,433						41
42	Land Improvements	1995	4,302						42
43	Building Improvements	1995	121,882						43
44	SMOKE DAMPER	1996	853						44
45	WALLCOVERING	1996	358						45
46	TILE	1996	5,333						46
47	PLUMBING FOR BEAUTY SHOP	1996	3,735						47
48	CABINETS IN PERSONAL CARE	1996	2,450						48
49	ELECTRICAL WIRING FOR PERSONAL	1996	1,740						49
50	TILE FLOOR	1996	824						50
51	ADDITIONAL COST TILE FLOOR	1996	189						51
52	PAINT	1996	1,025						52
53	ADDITIONAL COST A/C (DUCTWORK)	1996	262						53
54	CARPET	1996	846						54
55	COUNTERTOP	1996	894						55
56	PAINTING	1996	1,172						56
57	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278						57
58	HVAC	1996	600						58
59	WALLCOVERING	1996	2,112						59
60	FLOORING	1996	514						60
61	ADDITIONAL WALLCOVERING	1996	6						61
62	WALLCOVERING	1996	382						62
63	CONCRETE	1996	8,812						63
64	PAVING	1996	7,710						64
65	PAVING	1996	13,835						65
66	RENOVATION CHARGES (DUMPSTER)	1996	210						66
67	PAVING-AUDIT ADJ 7/1/03 (#10) - CHG YR	1996	2,652						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,458,287	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	70

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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		\$ 2,458,287	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	ANGLE BRACKETS FOR HANDRAIL	1997	700						2
3	WALLCOVERING	1997	599						3
4	HANDRAIL	1997	10,069						4
5	PAINTING & WALLCOVERING	1997	15,003						5
6	PAINTING	1997	2,500						6
7	ADDITIONAL COST FOR HANDRAIL	1997	1,480						7
8	COVE BASE	1997	671						8
9	WALL PROTECTION	1997	2,192						9
10	PAINTING & WALLCOVERING	1997	18,964						10
11	(2) NURSES STATION SYSTEMS	1997	11,176						11
12	WALLCOVERING	1997	24						12
13	ELECTRICAL WIRING. OUTLETS & T	1997	3,420						13
14	PAINTING, WALLCOVERING & COVE	1997	19,206						14
15	ADDLT COST FOR A/C	1997	105						15
16	NURSES STATION SYSTEM	1997	4,625						16
17	RENOVATE SHOWER ROOM	1997	939						17
18	A/C HEAT	1997	15,762						18
19	ROOF	1997	3,444						19
20	RENOVATE CENTRAL BATH	1997	2,475						20
21	PLUMBING IN KITCHEN	1997	1,102						21
22	ADDL'T COST FOR A/C	1997	105						22
23	VINLY WALL COVERING FROM INVENTORY	1997	2,425						23
24	HVAC	1997	682						24
25	ADDL'T COST FOR GENERATOR	1997	2,233						25
26	NURSES STATION SYSTEM	1997	1,600						26
27	CABINETS FOR BKKPG & MED RECOR	1997	5,432						27
28	HVAC (ADDL'T COST)	1997	880						28
29	ADDL'T RENOVATION COST	1997	28						29
30	REMODEL BOOKKEEPING OFFICE	1997	150						30
31	ADDL'T GENERATOR COST	1997	120						31
32	CARPET	1997	737						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,135	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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		\$ 2,587,135	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	DRYWALL	1997	2,750						2
3	PERIMETER ALARM SYSTEM	1997	5,972						3
4	WALLCOVERING	1997	651						4
5	SIDEWALKS	1997	5,875						5
6	Ceiling Tile For Nurses Station	1998	1,446						6
7	Additional Cost for Tile Floor	1998	291						7
8	Wallcovering	1998	414						8
9	Misc Labor & Materials for Gutters	1998	215						9
10	Excavation of Ditch & Storm Sewers	1998	975						10
11	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						11
12	ELECTRICAL WIRING	1998	665						12
13	ADDL'T COST ON FLOORING	1998	16						13
14	ADDL'T COST FOR COUNTERTOPS	1998	604						14
15	TILE FLOOR	1998	704						15
16	CUMMINS/ONAN GENERATOR	1998	24,882						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						17
18	FIRE ALARM CONTROL PANEL	1998	7,925						18
19	A/C HEAT ROOF	1998	672						19
20	GENERATOR	1998	303						20
21	FIRE ALARM SYSTEM	1998	17,066						21
22	GENERATOR	1998	25,364						22
23	HVAC RENOVATION	1998	646						23
24	Audit Adj 7/1/03 (#11) - Pg 12C, Line 23	1998	(646)						24
25	HVAC	1998	283,462						25
26	Audit Adj 7/1/03 (#12) - Pg 12C, Line 25	1998	(5,103)						26
27	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						27
28	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						28
29	PAINTING & WALLCOVERING	1999	3,457						29
30	DUCTWORK	1999	467						30
31	RE-KEY FACILITY	1999	779						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,993,418	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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		\$ 2,993,418	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	OVERHEAD FROM CONSTRUCTION	1999	4,880						2
3	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 2	1999	(4,880)						3
4	OVERHEAD FROM CONSTRUCTION	1999	27,042						4
5	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 4	1999	(27,042)						5
6	PAINTING	1999	1,245						6
7	EXIT FIXTURES	1999	2,074						7
8	ARMSTRONG FLOORING	1999	443						8
9	SPRINKLER UPGRADE	1999	14,500						9
10	LOCKING DOOR HARDWARE	1999	2,516						10
11	SPRINKLER UPGRADE	1999	14,500						11
12	DOOR LOCKS	1999	1,434						12
13	PLUMBING IN RESTROOMS	1999	1,330						13
14	SPRINKLER UPGRADE	1999	26,084						14
15	EXIT LIGHT	1999	2,074						15
16	FLOW SWITCH FOR SPRINKLER SYST	1999	342						16
17	QUARRY TILE	1999	9,916						17
18	SPRINKLER UPGRADE	1999	5,798						18
19	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 18	1999	(2,900)						19
20	SMOKE DOORS	1999	1,184						20
21	HVAC	1999	1,557						21
22	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						22
23	DOORS AND DOOR OPENERS	1999	3,500						23
24	DOORS AND FRAMES	1999	11,283						24
25	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						25
26	SECURE CARE SYSTEM	1999	15,373						26
27	DOORS	1999	2,750						27
28	DOOR	1999	200						28
29	EXTERIOR DOORS	1999	10,170						29
30	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						30
31	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 30	1999	(2,146)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,124,941	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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		\$ 3,124,941	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	DOOR ALARM	1999	1,475						2
3	SIDEWALKS	1999	9,020						3
4	SMOKING SHELTER	1999	4,950						4
5	PAVING	1999	4,950						5
6	WALLCOVERING	2000	61						6
7	UPGRADE FIRE ALARM SYST	2000	1,121						7
8	CABINETS FOR BUSINESS OFFICE	2000	2,821						8
9	ELECTRICAL FOR BUS OFFICE	2000	375						9
10	ALARM SYSTEM REPAIRS	2000	808						10
11	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						11
12	AUDIT ADJ 7/1/03 (#15) - PG12E, LINE 11	2000	(10,258)						12
13	HVAC	2000	18,151						13
14	HVAC CONSULTANT	2000	1,080						14
15	CARPET	2000	820						15
16	ADDL'T COST COUNTER TOPS	2000	313						16
17	CABINETS	2000	2,391						17
18	CARPET	2000	1,931						18
19	THERMO STAT	2000	1,594						19
20	FRT ON CARPET	2000	72						20
21	SOIL UTILITY RENOVATION	2000	3,240						21
22	SOIL UTILITY RENOVATION	2000	360						22
23	CABINETS/COUNTERTOPS	2000	266						23
24	KITCHEN HVAC	2000	2,017						24
25	SOIL UTILITY RENOVATION	2000	2,640						25
26	DUMPSTER ENCLOSURE	2001	2,457						26
27	WALLCOVERINGS	2001	121						27
28	ADDITIONAL COST PAINTING & VWC	2001	1,238						28
29	PAINTING & VWC	2001	138						29
30	CUSTOM CABINETS	2001	5,289						30
31	INSTALL CARPET	2001	641						31
32	(42) WINDOWS & INSTALLATION	2001	22,328						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,217,609	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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 12E, Carried Forward		\$ 3,217,609	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						2
3	PAINTING	2001	2,880						3
4	PAINTING	2001	320						4
5	General Constr. - Plumbing	2002	1,236						5
6	Interior Renov. - Wallcoverings	2002	822						6
7	AUDIT ADJ 7/1/03 (#16) - PG12F, LINE 6	2002	(822)						7
8	Interior Renov. - Wallcoverings	2002	44,760						8
9	Interior Renov. - Plumbing	2002	1,394						9
10	Building Addition - Wallcovering	2002	4,077						10
11	Border	2002	154						11
12	Additional Cost - Wallcovering	2002	196						12
13	Additional Cost - Wallcovering	2002	481						13
14	HVAC Electrical & Plumbing	2002	33,930						14
15	HVAC Electrical & Plumbing	2002	3,770						15
16	VWC	2002	496						16
17	Building Addition - Landscaping	2002	1,190						17
18	Building Addition - Landscaping	2002	6,442						18
19	Flooring and VWC	2002	4,823						19
20	Carpeting, Painting and Wallcovering	2003	12,897						20
21	7/1/06 Capital Rate Adj #1	2003	(12,897)						21
22	Developers Costs - Overhead	2003	211,116						22
23	7/1/06 Capital Rate Adj #2	2003	(211,116)						23
24	Architect & Engineering Fees	2003	91,070						24
25	Reproduc, Permit & Plan Fees	2003	15,980						25
26	7/1/06 Capital Rate Adj #3	2003	(5,165)						26
27	7/1/06 Capital Rate Adj #4	2003	(10,815)						27
28	Developers Costs - Interest	2003	16,397						28
29	7/1/06 Capital Rate Adj #5	2003	(16,397)						29
30	Millwork & Electric Service	2003	17,781						30
31	7/1/06 Capital Rate Adj #6	2003	(4,641)						31
32	7/1/06 Capital Rate Adj #7	2003	(13,140)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,417,309	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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 12F, Carried Forward		\$ 3,417,309	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	1
2	Developers Costs - Overhead	2003	3,196						2
3	7/1/06 Capital Rate Adj #8	2003	(3,196)						3
4	Developers Costs - Interest	2003	276						4
5	7/1/06 Capital Rate Adj #9	2003	(276)						5
6	Carpeting, Painting and Wallcovering	2003	47,947						6
7	Soil & Concrete Testing	2003	3,480						7
8	Water & Sewer Fees	2003	120						8
9	7/1/06 Capital Rate Adj #10	2003	(120)						9
10	Site Work General Contractor	2003	32,561						10
11	7/1/06 Capital Rate Adj #11	2003	(32,561)						11
12	Retro Cost Adjustment	2003	45,504						12
13	7/1/06 Capital Rate Adj #12	2003	(45,504)						13
14	Window Treatments	2003	8,850						14
15	Soil and Concrete Testing (Addtl Costs)	2003	2,110						15
16	7/1/06 Capital Rate Adj #15	2003	(2,110)						16
17	Engineering Fees	2003	9,194						17
18	7/1/06 Capital Rate Adj #16	2003	(9,194)						18
19	Double Egress Door	2004	5,905						19
20	Construction Drawings & Specs	2004	5,998						20
21	Carpetry, Case Work, Painting	2004	37,880						21
22	Retainage for Addition	2005	1,533						22
23	Flooring, Corner Guards	2005	14,903						23
24	7/1/06 Capital Rate Adj #13	2005	(1,455)						24
25	7/1/06 Capital Rate Adj #14	2005	(55)						25
26	Materials to Complete Addition Project	2005	24,280						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,566,575	\$ 158,480		\$ 158,480	\$	\$ 2,060,043	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 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	\$ 1,073,570	\$ 82,297	\$ 82,297	\$		\$ 800,628	71
72	Current Year Purchases	52,651						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			8,701	8,701			74
75	TOTALS	\$ 1,126,221	\$ 82,297	\$ 90,998	\$ 8,701		\$ 800,628	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	1986	\$ 20,573	\$	\$	\$		\$ 20,573	76
77		Chair Lift for Van	1990	1,260					1,260	77
78		Running Board for Van	1995	877					877	78
79										79
80	TOTALS			\$ 22,710	\$	\$	\$		\$ 22,710	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	4,821,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	240,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	249,478	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	8,701	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,883,381	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	CIP	\$ 652,434	92
93			93
94			94
95		\$ 652,434	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: \$ 27,084

Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$	5,878	\$ 146,948	\$ 265	5,878	\$ 147,213	1
2	Licensed Speech and Language Development Therapist	10a	hrs		2,958	73,943	209	2,958	74,152	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		5,716	142,900	6,944	5,716	149,844	4
5	Physician Care		visits							5
6	Dental Care		visits			148			148	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				145,802		145,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab, EKG, X-Ray	10, Col 3, 39				94,714			94,714	13
14	TOTAL			\$	14,552	\$ 458,653	\$ 153,220	14,552	\$ 611,873	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-Macomb# 0041822Report 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	\$ 436	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (11,867))	501,279		3
4	Supply Inventory (priced at)	34,600		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 536,315	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	3,566,577		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,148,929		16
17	Accumulated Depreciation (book methods)	(2,883,381)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP, Goodwill</u>	655,420		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,593,790	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,130,105	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,895	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,672		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,174		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	33,856		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 290,597	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	581,402		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)	\$ 581,402	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 871,999	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,258,106	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,130,105	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,165,611	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,165,611	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	759,985	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)	\$ 759,985	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(667,490)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (667,490)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,258,106	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Macomb

0041822

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,842,314	1
2	Discounts and Allowances for all Levels	7,556	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,849,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	833,369	6
7	Oxygen	3,865	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 837,234	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	80	12
13	Barber and Beauty Care	8,541	13
14	Non-Patient Meals	28,723	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,543	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,659	19
20	Radiology and X-Ray	28,835	20
21	Other Medical Services	726	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 331,107	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	339	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 339	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Disc	(1)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,018,549	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	642,750	31
32	Health Care	1,911,074	32
33	General Administration	1,039,605	33
B. Capital Expense			
34	Ownership	360,209	34
C. Ancillary Expense			
35	Special Cost Centers	304,926	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)*	\$ 4,258,564	40
41	Income before Income Taxes (line 30 minus line 40)**	759,985	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 759,985	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-Macomb

0041822

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	2,183	2,373	\$ 65,500	\$ 27.60	1
2	Assistant Director of Nursing	3,951	4,295	95,299	22.19	2
3	Registered Nurses	5,878	6,390	128,602	20.13	3
4	Licensed Practical Nurses	21,189	23,034	377,385	16.38	4
5	CNAs & Orderlies	51,942	56,463	530,119	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	28	30	317	10.57	8
9	Activity Director					9
10	Activity Assistants	6,209	6,761	75,467	11.16	10
11	Social Service Workers	4,394	4,747	70,992	14.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,593	16,959	170,761	10.07	15
16	Dishwashers					16
17	Maintenance Workers	2,895	3,148	37,816	12.01	17
18	Housekeepers	6,582	7,155	57,643	8.06	18
19	Laundry	4,241	4,614	51,570	11.18	19
20	Administrator	2,378	2,378	69,775	29.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,716	7,558	104,858	13.87	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	4,062	4,415	50,747	11.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,241	150,320	\$ 1,886,851 *	\$ 12.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	5,400	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)		\$ 5,400		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	12	120	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	12	\$ 120		53

Facility Name & ID Number Heartland Health Care Center-Macomb

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 \$2,627 ALLIANCE \$ 2,211
- (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 \$ 3,016
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,624 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. \$ 44,197
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. \$ (28,723)
- (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.