

		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: 0041830

Facility Name: Heartland Health Care Center-Moline

Address: 833 Sixteenth Avenue Moline 61265
 Number City Zip Code

County: Rock Island

Telephone Number: (309) 764-6744 **Fax #** (309) 764-8176

HFS ID Number: 344402510012

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 1/1/2006 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-Moline# 0041830 Report Period Beginning: 1/1/2006 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 11/13/06

	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>139</u>	Skilled (SNF)	<u>149</u>	<u>51,045</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>139</u>	TOTALS	<u>149</u>	<u>51,045</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>3,178</u>	<u>21,072</u>	<u>13,664</u>	<u>37,914</u>	8
9	SNF/PED					9
10	ICF		<u>10,941</u>	<u>301</u>	<u>11,242</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,178</u>	<u>32,013</u>	<u>13,965</u>	<u>49,156</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.30%

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 01/01/83

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

YES Date 10/16/98 NO

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

YES NO If YES, enter number of beds certified 118 and days of care provided 13,225Medicare Intermediary National Government Svc. (formerly AdminiStar Federal)

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-Moline # 0041830 Report Period Beginning: 1/1/2006 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	309,922	17,444	2,315	329,681	2,747	332,428		332,428			1
2	Food Purchase		255,710		255,710		255,710	(3,283)	252,427			2
3	Housekeeping	192,139	16,650	1,380	210,169		210,169		210,169			3
4	Laundry	75,272	11,459	342	87,073		87,073		87,073			4
5	Heat and Other Utilities			174,317	174,317	6,438	180,755	(9,939)	170,816			5
6	Maintenance	45,059	9,546	61,646	116,251		116,251		116,251			6
7	Other (specify):* Med Waste			670	670		670		670			7
8	TOTAL General Services	622,392	310,809	240,670	1,173,871	9,185	1,183,056	(13,222)	1,169,834			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	2,309,136	164,651	86,872	2,560,659	4,351	2,565,010	(4,073)	2,560,937			10
10a	Therapy		5,839	838,586	844,425		844,425		844,425			10a
11	Activities	126,069	12,419	473	138,961		138,961		138,961			11
12	Social Services	107,614	451	473	108,538		108,538		108,538			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,542,819	183,360	936,904	3,663,083	4,351	3,667,434	(4,073)	3,663,361			16
	C. General Administration											
17	Administrative	150,309		389,529	539,838	(77,222)	462,616		462,616			17
18	Directors Fees											18
19	Professional Services			2,254	2,254	(177)	2,077	(2,077)				19
20	Dues, Fees, Subscriptions & Promotions			76,628	76,628	177	76,805	(57,955)	18,850			20
21	Clerical & General Office Expenses	205,895	55,829	42,024	303,748		303,748	(28,258)	275,490			21
22	Employee Benefits & Payroll Taxes			714,866	714,866	47,471	762,337		762,337			22
23	Inservice Training & Education			2,661	2,661		2,661		2,661			23
24	Travel and Seminar			18,086	18,086		18,086		18,086			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			147,008	147,008		147,008		147,008			26
27	Other (specify):* PersPurch Admin			467	467		467		467			27
28	TOTAL General Administration	356,204	55,829	1,393,523	1,805,556	(29,751)	1,775,805	(88,290)	1,687,515			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,521,415	549,998	2,571,097	6,642,510	(16,215)	6,626,295	(105,585)	6,520,710			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-Moline #0041830 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			375,579	375,579	16,215	391,794		391,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,308	148,308		148,308		148,308			32
33	Real Estate Taxes			101,690	101,690		101,690	4,994	106,684			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			62,196	62,196		62,196		62,196			35
36	Other (specify):*											36
37	TOTAL Ownership			687,773	687,773	16,215	703,988	4,994	708,982			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			10,731	10,731		10,731	(10,731)				38
39	Ancillary Service Centers		303,993		303,993		303,993		303,993			39
40	Barber and Beauty Shops			15,438	15,438		15,438		15,438			40
41	Coffee and Gift Shops	149,455			149,455		149,455		149,455			41
42	Provider Participation Fee			75,895	75,895		75,895		75,895			42
43	Other (specify):* IV Therapy Drugs		23,428	40,328	63,756		63,756		63,756			43
44	TOTAL Special Cost Centers	149,455	327,421	142,392	619,268		619,268	(10,731)	608,537			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,670,870	877,419	3,401,262	7,949,551		7,949,551	(111,322)	7,838,229			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-Moline

0041830

Report Period Beginning: 1/1/2006

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	(3,283)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,939)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,439)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,077)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,745)	21		24
25	Fund Raising, Advertising and Promotional	(57,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	4,994	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,878)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (111,322)		\$	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))	\$ (111,322)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heartland Health Care Center-Moline

ID# 0041830

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	General Store	\$ (10)	21	1
2	Transportation Revenue	(4,785)	10	2
3	Transportation Expense	712	10	3
4	Ambulance Expense	(10,731)	38	4
5	Personal Purchases	(1,064)	21	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	(15,878)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,283)	0	0	0	0	0	0	0	0	0	0	(3,283)	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	(9,939)	0	0	0	0	0	0	0	0	0	0	(9,939)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,222)	0	0	0	0	0	0	0	0	0	0	(13,222)	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	(4,073)	0	0	0	0	0	0	0	0	0	0	(4,073)	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	(4,073)	0	0	0	0	0	0	0	0	0	0	(4,073)	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	(2,077)	0	0	0	0	0	0	0	0	0	0	(2,077)	19
20	Fees, Subscriptions & Promotions	(57,955)	0	0	0	0	0	0	0	0	0	0	(57,955)	20
21	Clerical & General Office Expenses	(28,258)	0	0	0	0	0	0	0	0	0	0	(28,258)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(88,290)	0	0	0	0	0	0	0	0	0	0	(88,290)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,585)	0	0	0	0	0	0	0	0	0	0	(105,585)	29

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Moline

0041830 Report Period Beginning:

1/1/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	4,994	0	0	0	0	0	0	0	0	0	0	4,994	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	4,994	0	4,994	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(10,731)	0	0	0	0	0	0	0	0	0	0	(10,731)	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	(10,731)	0	(10,731)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(111,322)	0	(111,322)	45									

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

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
ManorCare, Inc.	100	Health Care & Retirement Corp. of America (SEE H.O. COST REPORT)	Toledo, Ohio			

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	\$ 389,529	HCR ManorCare, Inc.	100.00%	\$ 389,529	\$
2	V	Page					
3	V	e					
4	V						
5	V						
6	V	10a Therapy Management	14,828	Heartland Management Services	100.00%	14,828	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 404,357			\$ 404,357	\$ *

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

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2006 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-Moline

0041830

Report Period Beginning: 1/1/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit Street
 City / State / Zip Code Toledo, Ohio 43604
 Phone Number (419-252-5500
 Fax Number (419-252-5495

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. Facs.	\$	\$	7,677,218	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	1,156,548	625,878	7,677,218	2,747	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Facs.	500,452		7,677,218	1,475	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	2,089,736		7,677,218	4,963	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Facs.			7,677,218	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	1,831,963	1,296,078	7,677,218	4,351	6
7	17	General & Administrative - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Facs.	41,206,110	32,327,667	7,677,218	121,439	7
8	17	General & Administrative - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	80,368,229	42,462,992	7,677,218	190,868	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Facs.	8,458,198		7,677,218	24,927	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	9,492,678		7,677,218	22,544	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Facs.			7,677,218	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Facs.	6,827,559		7,677,218	16,215	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	TOTALS					\$ 151,931,473	\$ 76,712,615		\$ 389,529	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			Purchase Facility	Oct. 3, 1991		\$ 389,893	\$ 389,893			\$ 148,308	1					
2	National City Bank, Trustee			Finance Capital Additions	3/97&11/97		972,504	972,504				2					
3	National City Bank, Trustee			Finance Capital Additions	6/01 & 9/01		1,010,547	1,010,547				3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 2,372,944	\$ 2,372,944			\$ 148,308	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 2,372,944	\$ 2,372,944			\$ 148,308	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

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.	\$	96,696	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.)	\$	101,690	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,994	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	101,690	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.	\$	106,684	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	107,537	8
	2002	91,152	9
	2003	94,996	10
	2004	95,846	11
	2005	101,690	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-Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0041830

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>08-533-28-00</u>	<u>See Attached</u>	\$ <u>25,422.52</u>	\$ <u>25,422.52</u>
2. <u>08-533-28-00</u>	<u>See Attached</u>	\$ <u>25,422.52</u>	\$ <u>25,422.52</u>
3. <u>08-533-28-00</u>	<u>See Attached</u>	\$ <u>25,422.52</u>	\$ <u>25,422.52</u>
4. <u>08-533-28-00</u>	<u>See Attached</u>	\$ <u>25,422.52</u>	\$ <u>25,422.52</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>101,690.08</u>	\$ <u>101,690.08</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-Moline

0041830 Report Period Beginning:

1/1/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,742 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1983</u>	<u>\$ 74,186</u>	<u>1</u>
2			<u>1986</u>	<u>106,824</u>	<u>2</u>
3	TOTALS			\$ 181,010	3

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

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	119		1996	1996	\$ 1,033,964	\$ 102,813	30	\$ 102,813		\$ 1,880,459	4
5				1893	56,519		5				5
6	10			1998	1,398,475		10-20				6
7	10			2001	709,498		40				7
8	10			2006	111,912						8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					165,836		165,836		1,859,804	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						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-Moline

0041830

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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

1	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		\$	\$		\$	\$	\$	37
38	Land Improvements	1995	980					38
39	Building Improvements	1995	32,598					39
40	Land Improvements: Sign, Landscatping, and Concrete Bumpers	1996	25,027					40
41	Building Improvements: Painting/Wallcovering, Carpet, Paging system,	1996	126,134					41
42	doors/fixtures,millwork,air conditioning, moving/storage, cabinets,							42
43	hand rails,electrical wiring, ceramic tile, and bathroom sinks							43
44	Building Improvements: Fire alarm	1996	45,151					44
45	Building Improvements: Intercom system	1996	27,230					45
46	Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414					46
47	architect and engineering fees, interior design costs, drywall and							47
48	corner guards, aluminum chips, electrical heating, air conditioning							48
49	fire stop installation and access doors, and storage fees							49
50	Building Improvements: Wallcovering	1996	118,024					50
51	Building Improvements: Sewer Runs	1997	10,708					51
52	Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159					52
53	door frames, millwork, carpetry, caulking, ceilings plaster,							53
54	plumbing comosite, electrical composite, sinks, conduit wiring,							54
55	door closing devices, nurses call system							55
56	Building Improvements: 18 Bed Addition, wallcovering, comncrete,	1997	334,930					56
57	doors wood, telephone system, fencing wire, electrical transformer,							57
58	HVAC, hollow metal doors, duct work							58
59	Building Improvements: Install HVAC, electrical composite	1997	291,760					59
60	Building Improvements: Roof Replacement	1997	49,483					60
61	Building Improvements: Door	1997	1,042					61
62	Building Improvements: Siding on new additon	1997	4,993					62
63	Building Improvement: VWC from Inventory	1997	1,464					63
64	Land Improvements: Sign	1997	593					64
65	Land Improvements: Landscaping	1997	801					65
66	Land Improvements: Fence	1997	5,422					66
67	Bldg. Improvements: Cupola	1998	5,440					67
68	Bldg. Improvements: HVAC	1998	23,069					68
69								69
70	TOTAL (lines 4 thru 69)		\$ 5,254,999	\$ 268,649		\$ 268,649	\$ 3,740,263	70

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

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

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		\$ 5,254,999	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	1
2	Bldg. Improvements: Roof	1998	8,203						2
3	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						3
4	Bldg. Improvements: Add't HVAC	1998	15,464						4
5	Bldg. Improvements: 8 Bed Addition	1998	88,423						5
6	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						6
7	Land Improvements: Grading	1998	1,779						7
8	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						8
9	Bldg. Improvements: Doors	1998	10,151						9
10	Asphalt Work	1999	14,164						10
11	Smoking Shelter	1999	5,254						11
12	Overhead from Const	1999	29,447						12
13	Concrete Pad for Smoking	1999	924						13
14	Exit Device	1999	474						14
15	Carpet	1999	994						15
16	Carpet	1999	553						16
17	Awning	1999	2,788						17
18	Building Decorations	1999	653						18
19	Retainage for Carpet	1999	73						19
20	Retainage Fee for Carpet	1999	59						20
21	Wallboard	1999	568						21
22	Wiring	1999	3,850						22
23	Wall, Drain Lines, Electrica	1999	15,776						23
24	Boiler Pump	2000	5,433						24
25	HVAC Upgrade	2000	1,600						25
26	Boiler room exhaust	2000	5,684						26
27	Phone line	2000	800						27
28	Phone line	2000	800						28
29	Ceramic tile	2000	511						29
30	Carpet	2000	842						30
31	Sinks & faucet	2000	1,055						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,541,500	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	34

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

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

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		\$ 5,541,500	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	1
2									2
3	Add'l cost sinks	2000	218						3
4	Add'l cost carpeting	2000	59						4
5	Add'l cost carpet	2000	94						5
6	Retainer on boiler room exhaust	2000	632						6
7	Replace door in laundry	2000	4,932						7
8	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						8
9	Bldg Imprv - Carpentry/Electrical	2001	60,645						9
10	Bldg Imprv - Wallcovering	2001	11,630						10
11	Land Imprv - Concrete work	2001	4,941						11
12	Land Imprv - Walkway & Canopy	2001	3,858						12
13	Wire Component Connection	2001	2,543						13
14	Wire Component Connection	2002	327						14
15	Wire Component Connection	2002	402						15
16	Building Addition - VWC - Corridor	2002	19,847						16
17	Paint, VWC - Corridor Renovation	2001	45,377						17
18	Corner Guards	2002	7,153						18
19	Mini-Edger	2002	729						19
20	Corner Guards - Asset adjustment	2002	(4,953)						20
21	Building Addition - Paving/Landscaping	2002	8,679						21
22	Building Addition - Paving/Landscaping	2002	8,397						22
23	Building Addition - Paving/Landscaping	2002	111,907						23
24	Paving	2002	5,025						24
25	2 Dell celeron	2002	1,687						25
26	Electrical Work Overhead & Interest	2003	55,146						26
27	Overhead & Interest	2003	8,734						27
28	General Construction	2003	5,540						28
29	Carpet and Flooring	2003	83,248						29
30	Floorcovering	2003	702						30
31	Floorcovering	2003	251						31
32	HVAC	2003	7,643						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,008,426	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	34

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

Facility Name & ID Number Heartland Health Care Center-Moline

0041830

Report Period Beginning:

1/1/2006

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		\$ 6,008,426	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	1
2									2
3	HVAC Kitchen retainage	2003	5,627						3
4	Overhead & Interest	2003	8,231						4
5	Overhead & Interest	2003	(8,231)						5
6	Retro Cost Adjustment	2003	84,377						6
7	Retro Cost Adjustment	2003	48,938						7
8	Sealcoat & Restripe Pkg.	2004	(48,938)						8
9	Sealcoat & Restripe Pkg.	2004	2,602						9
10	VWC	2004	68						10
11	Flooring and Painting	2004	1,486						11
12	VWC & Painting	2004	1,278						12
13	Carpet	2004	472						13
14	Interest	2005	3,449						14
15	Interest	2005	(3,449)						15
16	General Overhead	2005	46,589						16
17	General Overhead	2005	(46,589)						17
18	Fire Sprinkler System	2005	142,143						18
19	EXHAUST SYSTEM	2005	7,150						19
20	condensing unit	2006	4,193						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)		\$ 6,257,822	\$ 268,649		\$ 268,649	\$	\$ 3,740,263	34

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

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2006 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	\$ 1,831,188	\$ 106,930	\$ 106,930	\$		\$ 1,507,023	71
72	Current Year Purchases	109,713						72
73	Fully Depreciated Assets							73
74				16,215	16,215			74
75	TOTALS	\$ 1,940,901	\$ 106,930	\$ 123,145	\$ 16,215		\$ 1,507,023	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van with		\$ 22,049	\$	\$	\$		\$ 22,049	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			\$ 22,049	\$	\$	\$		\$ 22,049	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)	\$	8,401,782	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	375,579	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	391,794	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	16,215	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	5,269,335	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:	N/A			\$			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: \$ 62,196 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	N/A		\$	\$	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	\$	12,512	\$ 312,812	\$ 918	12,512	\$ 313,730	1
2	Licensed Speech and Language Development Therapist	10a	hrs		2,985	74,637	(18)	2,985	74,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		18,046	451,137	4,939	18,046	456,076	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				303,993		303,993	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39, 3								13
14	TOTAL			\$	33,543	\$ 838,586	\$ 309,832	33,543	\$ 1,148,418	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-Moline# 0041830Report Period Beginning: 1/1/2006

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	\$ 18,020	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (218,442))	1,067,351		3
4	Supply Inventory (priced at)	34,461		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)	\$ 1,119,832	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,010		13
14	Buildings, at Historical Cost	6,257,822		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,962,950		16
17	Accumulated Depreciation (book methods)	(5,269,335)		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 (spe CIP)	1,951,069		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,083,516	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,203,348	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 57,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	371,459		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,690		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	93,814		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 624,645	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,372,944		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	64,634		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,437,578	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,062,223	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,141,125	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,203,348	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,661,515	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,661,515	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	3,465,803	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)	\$ 3,465,803	17
B. Transfers (Itemize):			
18		(1,986,193)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,986,193)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,141,125	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Moline# 0041830Report Period Beginning: 1/1/2006Ending: 12/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,295,399	1
2	Discounts and Allowances for all Levels	(319,607)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,975,792	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,983,275	6
7	Oxygen	62,015	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,045,290	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	2,949	12
13	Barber and Beauty Care	19,452	13
14	Non-Patient Meals	1,408	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	316,369	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,750	19
20	Radiology and X-Ray	15,486	20
21	Other Medical Services	13,419	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 392,833	23
D. Non-Operating Revenue			
24	Contributions	1,439	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,439	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,415,354	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,173,871	31
32	Health Care	3,663,083	32
33	General Administration	1,805,556	33
B. Capital Expense			
34	Ownership	687,773	34
C. Ancillary Expense			
35	Special Cost Centers	619,268	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)*	\$ 7,949,551	40
41	Income before Income Taxes (line 30 minus line 40)**	3,465,803	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,465,803	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-Moline

0041830

Report Period Beginning: 1/1/2006

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	2,106	2,318	\$ 72,963	\$ 31.48	1
2	Assistant Director of Nursing	2,017	2,220	54,696	24.64	2
3	Registered Nurses	10,973	12,075	264,391	21.90	3
4	Licensed Practical Nurses	35,611	39,188	673,386	17.18	4
5	CNAs & Orderlies	101,597	112,047	1,204,178	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,911	12,029	126,069	10.48	10
11	Social Service Workers	5,617	6,191	107,614	17.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,624	29,352	309,922	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,070	2,281	45,059	19.75	17
18	Housekeepers	18,087	19,938	192,139	9.64	18
19	Laundry	6,483	7,144	75,272	10.54	19
20	Administrator	2,080	2,080	101,368	48.73	20
21	Assistant Administrator	1,890	1,890	48,941	25.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,144	13,183	205,895	15.62	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	1,852	2,041	39,522	19.36	31
32	Other Health C: B&B & Hosp.	11,513	12,692	149,455	11.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	250,575	276,669	\$ 3,670,870 *	\$ 13.27	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	10,500	5,9,3	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)		\$ 10,500	49	

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A		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-Moline

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 \$8,406
- (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? \$6,640
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,901 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. \$ 75,895
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. \$ 1,408
- (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? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.