

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0041798

Facility Name: Heartland Health Care Center-Canton

Address: 2081 North Main Street Canton 61520
 Number City Zip Code

County: Fulton

Telephone Number: (309) 647-6135 **Fax #** (309) 647-6141

HFS ID Number: 344402510002

Date of Initial License for Current Owners: 09/09/1988

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Craig Dekany **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 01/01/07 to 12/31/07 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-Canton

0041798 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 11/1/07

	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>82</u>	Skilled (SNF)	<u>90</u>	<u>30,418</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>16</u>	Sheltered Care (SC)	<u>0</u>	<u>4,864</u>	5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>90</u>	<u>35,282</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>7,106</u>	<u>12,889</u>	<u>6,194</u>	<u>26,189</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>1,635</u>		<u>1,635</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,106</u>	<u>14,524</u>	<u>6,194</u>	<u>27,824</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.86%

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

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

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

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

n/a

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

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

YES NO

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 9/26/1988

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

YES Date 1/1/1983 NO

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

YES NO If YES, enter number of beds certified 4,085 and days of care provided 4,085

Medicare Intermediary National Government Services (formerly Administar)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	183,528	12,736	9,278	205,542	1,624	207,166		207,166		1
2	Food Purchase		189,393		189,393		189,393	(1,062)	188,331		2
3	Housekeeping	106,490	16,787	2,039	125,316		125,316		125,316		3
4	Laundry	31,733	8,181	1,159	41,073		41,073		41,073		4
5	Heat and Other Utilities			129,159	129,159	3,724	132,883	(4,863)	128,020		5
6	Maintenance	35,603	8,895	69,435	113,933		113,933		113,933		6
7	Other (specify):*			882	882		882		882		7
8	TOTAL General Services	357,354	235,992	211,952	805,298	5,348	810,646	(5,925)	804,721		8
	B. Health Care and Programs										
9	Medical Director			21,800	21,800		21,800		21,800		9
10	Nursing and Medical Records	1,488,134	106,266	58,686	1,653,086	3,010	1,656,096	(33,941)	1,622,155		10
10a	Therapy	409,073	4,243	43,174	456,490		456,490	(595)	455,895		10a
11	Activities	68,543	3,694	2,672	74,909		74,909		74,909		11
12	Social Services	69,661	30	1,440	71,131		71,131		71,131		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,035,411	114,233	127,772	2,277,416	3,010	2,280,426	(34,536)	2,245,890		16
	C. General Administration										
17	Administrative	61,952		275,599	337,551	(58,230)	279,321		279,321		17
18	Directors Fees										18
19	Professional Services			9,173	9,173	(46)	9,127	(6,712)	2,415		19
20	Dues, Fees, Subscriptions & Promotions			94,443	94,443		94,443	(82,958)	11,485		20
21	Clerical & General Office Expenses	163,940	40,659	953	205,552	46	205,598	23,963	229,561		21
22	Employee Benefits & Payroll Taxes			602,159	602,159	38,066	640,225		640,225		22
23	Inservice Training & Education			732	732		732		732		23
24	Travel and Seminar			13,915	13,915		13,915		13,915		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,656	108,656		108,656		108,656		26
27	Other (specify):*										27
28	TOTAL General Administration	225,892	40,659	1,105,630	1,372,181	(20,164)	1,352,017	(65,707)	1,286,310		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,618,657	390,884	1,445,354	4,454,895	(11,806)	4,443,089	(106,168)	4,336,921		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-Canton #0041798 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			273,713	273,713	11,470	285,183		285,183		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,335	4,335	336	4,671		4,671		32
33	Real Estate Taxes			61,062	61,062		61,062	(1,910)	59,152		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			47,914	47,914		47,914		47,914		35
36	Other (specify):*			22,099	22,099		22,099		22,099		36
37	TOTAL Ownership			409,123	409,123	11,806	420,929	(1,910)	419,019		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		126,378		126,378		126,378		126,378		39
40	Barber and Beauty Shops		(973)	13,109	12,136		12,136		12,136		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			45,627	45,627		45,627		45,627		42
43	Other (specify):*		8,715	17,121	25,836		25,836		25,836		43
44	TOTAL Special Cost Centers		134,120	75,857	209,977		209,977		209,977		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,618,657	525,004	1,930,334	5,073,995		5,073,995	(108,078)	4,965,917		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-Canton

0041798

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,062)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,863)	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)	(10)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,529)	21		18
19	Entertainment				19
20	Contributions	(11)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,712)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	35,203	21		24
25	Fund Raising, Advertising and Promotional	(78,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,910)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(43,534)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,078)		\$	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)	\$ (108,078)		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-Canton

ID# 0041798

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Misc Income	\$ (4,700)	21	1
2	Non-Allowable Therapy	(595)	10a	2
3	AR Sub Fees	(4,308)	20	3
4	Tranportation Expense	(33,931)	10	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	(43,534)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(1,062)	0	0	0	0	0	0	0	0	0	0	(1,062)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,863)	0	0	0	0	0	0	0	0	0	0	(4,863)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,925)	0	0	0	0	0	0	0	0	0	0	(5,925)	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	(33,941)	0	0	0	0	0	0	0	0	0	0	(33,941)	10
10a	Therapy	(595)	0	0	0	0	0	0	0	0	0	0	(595)	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	(34,536)	0	0	0	0	0	0	0	0	0	0	(34,536)	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	(6,712)	0	0	0	0	0	0	0	0	0	0	(6,712)	19
20	Fees, Subscriptions & Promotions	(82,958)	0	0	0	0	0	0	0	0	0	0	(82,958)	20
21	Clerical & General Office Expenses	23,963	0	0	0	0	0	0	0	0	0	0	23,963	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	(65,707)	0	0	0	0	0	0	0	0	0	0	(65,707)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,168)	0	0	0	0	0	0	0	0	0	0	(106,168)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	(1,910)	0	0	0	0	0	0	0	0	0	0	(1,910)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,910)	0	(1,910)	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)	(108,078)	0	(108,078)	45									

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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, 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	\$ 275,599	HCR ManorCare, Inc.	100.00%	\$ 275,599	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	22,741	Heartland Management Services	100.00%	22,741	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 298,340			\$ 298,340	\$ *

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

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/07 Ending: 12/31/07

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-Canton

0041798

Report Period Beginning: 01/01/07

Ending: 12/31/07

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, OH 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	2,813,673,080	369 Nors. Fac.	\$ 59,848	\$ 4,830,179	\$ 103	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	1,061,370	577,717	4,830,179	1,521	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	497,772	4,830,179	855	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,002,556	4,830,179	2,869	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		4,830,179	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,100,636	1,287,391	4,830,179	3,010	6
7	17	Gen'l & Administrative-Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	41,222,846	32,327,667	4,830,179	70,766	7
8	17	Gen'l & Administrativ -Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	102,324,370	42,519,840	4,830,179	146,603	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	7,830,100	4,830,179	13,442	9	
10	22	Employy Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	17,187,062	4,830,179	24,624	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		4,830,179	0	11	
12	30	Depreciation - Polled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	8,005,430	4,830,179	11,470	12	
13									13	
14	32	Interest				3,167,921	4,830,179	336	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 185,459,911	\$ 76,712,615	\$ 275,599	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	National City Bank, Trustee		X	Finance Capital Additions	n/a		\$ 81,675	\$ 81,675			\$ 4,335	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 81,675	\$ 81,675			\$ 4,335	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 81,675	\$ 81,675			\$ 4,335	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 2006 report.		\$ <u>62,972</u>	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.)		\$ <u>61,062</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>(1,910)</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>61,062</u>	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.		\$ <u>59,152</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>57,972</u>	8
	2003	<u>61,246</u>	9
	2004	<u>64,285</u>	10
	2005	<u>62,972</u>	11
	2006	<u>61,062</u>	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Canton COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0041798

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 2006 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 2006.

(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>09-08-15-205-007</u>	<u>See Attached</u>	\$ <u>61,062.00</u>	\$ <u>61,062.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>61,062.00</u>	\$ <u>61,062.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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-Canton

0041798 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,903 B. General Construction Type: Exterior Brick Frame Wood 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>1988</u>	<u>\$ 55,973</u>	<u>1</u>
2			<u>2006</u>	<u>1,162</u>	<u>2</u>
3	TOTALS			\$ 57,135	3

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		1988	1988	\$ 1,936,360	\$ 72,544		\$ 72,544		\$ 1,283,651	4
5	AUDIT ADJ 7/1/03 (#1)			1988	(1,508)						5
6				1994	8,975						6
7				2006	364,683						7
8											8
	Improvement Type**										
9	Land Improvements (Current Year Depreciation)										
10	Site Work			1988	125,431	115,643		115,643		842,118	10
11	Sewer & Water Lines			1988	85,093						11
12	Paving			1988	82,940						12
13	Yew Trees			1991	4,440						13
14	Landscaping - Stone Wall			1992	3,812						14
15	Drain Tiles and Catch Basins			1992	7,550						15
16	AUDIT ADJ 7/1/03 (#2) - Drain Tiles			1992	(45)						16
17	AUDIT ADJ 7/1/03 (#2) -Reverse Adjustment			1992	45						17
18	Credit on Land Imp-CNCLD Retainer			1992	(755)						18
19	Fire Rated Door - Staff Development			1992	2,444						19
20	Plumbing - Mixing Valve			1992	676						20
21	Carpeting			1992	5,804						21
22	AUDIT ADJ 7/1/03 (#3) - Carpeting			1992	(5,804)						22
23	Carpet Vestibule Lounge - AUDIT ADJ 7/1/03 (#4) - CHG YEAR			1992	5,804						23
24	Renovation (Moved from CIP in 1995)			1993	5,360						24
25	Electrical (Moved from CIP in 1995)			1993	1,748						25
26	Aluminum Awning			1993	1,376						26
27	Wood Fence for Courtyard			1993	1,785						27
28	Replace Sod			1993	2,575						28
29	Seal & Stripe Parking Lot			1994	7,564						29
30	Painting			1994	994						30
31	Interior DR Remodel, Carpentry			1994	8,650						31
32	Elec, Plumb, DR Remodel			1994	5,130						32
33	Sprinkler Sys			1994	1,193						33
34	Carpet Lobby, Offices, Nurses Station			1994	13,908						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-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Sidewalk	1995	\$ 4,440	\$		\$	\$	\$	37
38	Fencing	1995	1,732						38
39	Vinyl Flooring	1995	949						39
40	Electrical	1995	1,154						40
41	Cabinets in Alzheimers Unit	1995	1,394						41
42	Counter Top	1995	244						42
43	Doors	1995	7,346						43
44	Architectural Fees A/L Lounge Renovation	1995	2,231						44
45	Electrical Engineering and Architectural Service Fees-CHG YR	1995	9,766						45
46	Carpet	1996	181						46
47	Painting	1996	1,750						47
48	Painting	1996	1,806						48
49	Labor, Material, Permits to Renovate A/L Lounge	1996	5,615						49
50	Carpeting	1996	1,060						50
51	(51) Doors	1996	8,278						51
52	Grilles for Sliding Glass Door for A/L Lounge	1996	181						52
53	Credit on BLD IMP- CNCLD Retainer	1996	(18)						53
54	Ceramic Tile	1996	3,511						54
55	Painting	1997	148						55
56	Architectural Services	1997	375						56
57	Architectural Services -Alzheimers Unit	1997	2,075						57
58	Additional Architectural Services	1997	500						58
59	Architectural Services - Alzheimers Unit	1997	575						59
60	Add'l HVAC Cost	1997	232						60
61	Architectural Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	3,725						61
62	Engineering Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	250						62
63	Construction Overhead and Interest-AUDIT ADJ 7/1/03 (#7) CHG	1997	18,034						63
64	HVAC - AUDIT AJD 7/1/03 (#7) CHG YEAR	1997	194,747						64
65	Lift Station - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	25,000						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,973,510	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	70

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 2,973,510	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	1
2	HVAC	1998	35,458						2
3	A/C DESIGN & INSTALLATION	1998	36,185						3
4	AA ON ROOFTOP UNIT	1998	7,360						4
5	ROOF TOP UNIT	1998	11,100						5
6	FACIA BOARD & GUTTERS	1998	13,000						6
7	Asphalt Paving	1998	17,441						7
8	INSTALL HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,475						8
9	INSTALL DAMPER HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	643						9
10	INSTALL RTU HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,200						10
11	WALLCOVERINGS	1999	5,319						11
12	CONSTRUCTION OVERHEAD	1999	11,221						12
13	AUDIT ADJ 7/1/03 (#8) - OVERHEAD	1999	(11,221)						13
14	WALLCOVERINGS	1999	4,097						14
15	AUDIT ADJ 7/1/03 (#9) - WALLCOVERINGS	1999	(225)						15
16	SECURE CARE LOCKING SYSTEM	1999	5,101						16
17	PARTITIONS	1999	738						17
18	WALLCOVERINGS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,233						18
19	CORNER GUARDS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	251						19
20	COVE BASE-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	539						20
21	LOREN COOK ROOF EXHAUST-AUDIT ADJ 7/1/03 (#10) CHG	1999	1,325						21
22	WALL VINYL COVERING	1999	1,936						22
23	CABINETS & TOPS	1999	5,247						23
24	PAINTING	1999	1,450						24
25	PAINTING	1999	17,000						25
26	AUDIT ADJ 7/1/03 (#11) - PAINTING	1999	(17,000)						26
27	FLOORING - COVE BASE	1999	1,258						27
28	CUSTOM CABINETS	1999	5,820						28
29	PAINTING	1999	15,000						29
30	CEILING INSTALLATION-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1999	10,367						30
31	AUDIT ADJ 7/1/03 (#13) - CEILING INSULATION	1999	(10,367)						31
32	DESIGN FEES FOR ALZHEIMERS UNIT	1999	1,050						32
33	DESIGN FEES FOR ALZHEIMERS UNIT	1999	(1,050)						33
34	TOTAL (lines 1 thru 33)		\$ 3,146,463	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	34

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,146,463	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	1
2	WALLCOVERING	1999	132						2
3	WALLCOVERING	1999	116						3
4	WALLCOVERING	1999	496						4
5	COOLER	1999	1,245						5
6	AUDIT ADJ 7/1/03 (#14) - COOLER	1999	(1,245)						6
7	WALLCOVERING	1999	744						7
8	AUDIT ADJ 7/1/03 (#15) - WALLCOVERING	1999	(744)						8
9	PAINTING	1999	33,450						9
10	AUDIT ADJ 7/1/03 (#16) - PAINTING	1999	(33,450)						10
11	CABINETRY & COUNTERTOPS	1999	11,067						11
12	AUDIT ADJ 7/1/03 (#17) - CABINETRY	1999	(11,067)						12
13	CARPETING & FLOORING	1999	1,258						13
14	AUDIT ADJ 7/1/03 (#18) - CARPETING	1999	(1,258)						14
15	HVAC	1999	3,318						15
16	AUDIT ADJ 7/1/03 (#19) - HVAC	1999	(3,318)						16
17	CEILING INSTALLATION	1999	10,367						17
18	AUDIT ADJ 7/1/03 (#20) - CEILING INSTALLATION	1999	(10,367)						18
19									19
20	FLOORING	2000	24,374						20
21	CONSTRUCTION OVERHEAD AND INTEREST	2000	31,653						21
22	AUDIT ADJ 7/1/03 (#21) - CONSTRUCTION	2000	(31,653)						22
23	DOOR HOLDERS	2000	1,623						23
24	FLOOR COVERING	2000	1,495						24
25	DRY SPRINKLER SYSTEM	2000	1,381						25
26	DRYWALL	2000	6,160						26
27	FREIGHT ON FABRIC	2001	534						27
28	FURNISH & INSTALL HANDRAILS	2001	943						28
29	DOORS	2001	4,200						29
30	ROOF	2001	13,000						30
31	COVE BASE	2001	5,885						31
32	AUDIT ADJ 7/1/03 (# 26) - COVE BASE	2001	(5,885)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,200,918	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	34

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,200,918	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	1
2	RESIDENT ROOM PAINTING	2002	4,484						2
3	AUDIT ADJ 7/1/03 (# 27) - RESIDENT ROOM PAINTING	2002	(4,484)						3
4	RESIDENT ROOM PAINTING	2002	38,492						4
5	AUDIT ADJ 7/1/03 (#22) - PAINTING	2002	(2,814)						5
6	DOORS	2002	3,225						6
7	GENERAL CONSTRUCTION	2002	9,542						7
8	RENOVATION ELECTRICAL-AUDIT ADJ 7/1/03 (#24) CHG YE	2002	61,600						8
9	AUDIT ADJ 7/1/03 (#23) - RENOVATION ELECTRICAL	2002	(2,284)						9
10	STAINLESS STEEL VWC	2002	9,059						10
11	STAINLESS STEEL VWC	2002	1,007						11
12	ROOF	2003	17,781						12
13	ROOF	2003	970						13
14	7/1/06 CAPITAL RATE ADJUST #1	2003	(970)						14
15	ROOFING & SHEET METAL	2003	53,562						15
16	GENERAL CONSTRUCTION	2003	3,994						16
17	AUDIT ADJ 7/1/03 (#25) - GENERAL CONSTRUCTION	2003	(3,994)						17
18	CARPET AND INSTALL	2003	22,469						18
19	PAVING	2003	72,546						19
20	OVERHEAD & INTEREST	2003	8,586						20
21	AUDIT ADJ 12/03 (#1) OVERHEAD & INT	2003	(8,586)						21
22	AUDIT ADJ 7/1/03 (#5) - PG 12A LINE 47 + PG 12A LINE 55	2003	(2)						22
23	AUDIT ADJ 7/1/03 (#5) - REVERSAL	2003	2						23
24	CEILING	2004	1,817						24
25	WINDOW	2004	3,078						25
26	DOOR	2004	1,600						26
27	SHEET VINYL FLOORING	2004	7,250						27
28	CUSTOM CABINETS	2004	2,354						28
29	VCT AND COVE BASE	2004	2,250						29
30	ARCH & ENGINEERING COSTS	2005	2,420						30
31	ARCH & ENGINEERING COSTS	2005	423						31
32	HANDRAIL AND BACKER	2005	27,820						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,534,115	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	34

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 3,534,115	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	1
2	MAGNETIC DOOR	2005	2,515						2
3	METAL DOORS	2005	2,485						3
4	DOOR FRAMES	2005	24,900						4
5	ARCHITECT & ENGINEERING COSTS	2005	10,281						5
6	OVERHEAD & INTEREST	2005	10,238						6
7	7/1/06 CAPITAL RATE ADJUST #2	2005	(10,238)						7
8	INTEREST ON CONSTRUCTION	2005	735						8
9	7/1/06 CAPITAL RATE ADJUST #3	2005	(735)						9
10	WALLCOVERING	2005	1,452						10
11	7/1/06 CAPITAL RATE ADJUST #4	2005	(1,452)						11
12	PLAN REVIEWS	2005	2,400						12
13	BASIC ELECTRICAL	2005	71,574						13
14	INSTALLATION OF 10 PTAC UNITS	2005	616						14
15	GENERATOR	2006	7,415						15
16	GENERATOR	2006	5,493						16
17	INSTALLATION OF 5 PTAC UNITS	2006	3,275						17
18	ARCHITECT & ENGINEERING COSTS	2006	36,887						18
19	ARCHITECT & ENGINEERING COSTS	2006	6,472						19
20	ENGINEERING - CIVIL	2006	8,600						20
21	GENERAL OVERHEAD	2006	20,273						21
22	PLAN REVIEWS	2006	7,286						22
23	INTEREST ON CONSTRUCTION	2006	3,433						23
24	CARPETING & PADS	2006	1,615						24
25	WALLCOVERING	2006	1,845						25
26	SPRINKLERS	2006	1,075						26
27	HVAC	2006	3,417						27
28	VINYL WALL COVERING	2006	1,022						28
29	VINYL WALL COVERING	2006	130						29
30	CARPET	2006	1,085						30
31	CARPENTRY	2006	15,800						31
32	GENERAL CONTRACTOR - PT ADDITION	2006	98,220						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,872,226	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	34

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 3,872,226	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	1
2	SOIL TESTING	2006	4,866						2
3	CONCRETE TESTING	2006	188						3
4	CONCRETE PAD AND RAMP	2007	13,712						4
5	1006 NURSE CALL SYSTEM	2007	8,691						5
6	1006 NURSE CALL SYSTEM	2007	1,133						6
7	window glass	2007	1,089						7
8	RETAINAGE FOR WIRING	2007	1,164						8
9	WIRING	2007	10,476						9
10	FIRE ALARM MOTHERBOARD	2007	1,620						10
11	CARPENTRY	2007	23,900						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,939,065	\$ 188,187		\$ 188,187	\$	\$ 2,125,769	34

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

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 1,265,475	\$ 85,526	\$ 85,526	\$		\$ 984,095	71
72	Current Year Purchases	96,195						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			11,470	11,470			74
75	TOTALS	\$ 1,361,670	\$ 85,526	\$ 96,996	\$ 11,470		\$ 984,095	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,357,870	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 273,713	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,183	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,470	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,109,864	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 47,914 Description: 02 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	3654 hrs	\$ 138,320	630	\$ 15,740	\$ 1,124	4,284	\$ 155,184	1
2	Licensed Speech and Language Development Therapist	10a	1243 hrs	47,063	167	4,176		1,410	51,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5909 hrs	223,690	931	23,258	3,119	6,840	250,067	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10,3; 39,2	# of prescrpts			4,263	126,378		130,641	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Serv, Med Rec	39,3				49,023	5,400		54,423	13
14	TOTAL			\$ 409,073	1,728	\$ 96,460	\$ 136,021	12,534	\$ 641,554	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-Canton# 0041798Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ 44,392	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	667,896		3
4	Supply Inventory (priced at)	35,917		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	127		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 748,332	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,135		13
14	Buildings, at Historical Cost	3,939,063		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,361,671		16
17	Accumulated Depreciation (book methods)	(3,109,864)		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):	380,608		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,628,613	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,376,945	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (42,537)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(252,375)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(61,062)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		(45,608)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (401,582)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(81,675)		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)	\$ (81,675)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (483,257)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,860,202	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,376,945	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,629,376	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,629,376	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	292,292	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)	\$ 292,292	17
	B. Transfers (Itemize):		
18	Change in Interdivision	938,534	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 938,534	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,860,202	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning: 01/01/07

Ending: 12/31/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,403,231	1
2	Discounts and Allowances for all Levels	(180,294)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,222,937	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	966,379	6
7	Oxygen	1,464	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 967,843	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	795	12
13	Barber and Beauty Care	17,743	13
14	Non-Patient Meals	277	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	129,329	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,511	19
20	Radiology and X-Ray	1,942	20
21	Other Medical Services	3,201	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 170,798	23
D. Non-Operating Revenue			
24	Contributions	11	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		4,698	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,698	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,366,287	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	805,298	31
32	Health Care	2,277,416	32
33	General Administration	1,372,181	33
B. Capital Expense			
34	Ownership	409,123	34
C. Ancillary Expense			
35	Special Cost Centers	209,977	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,073,995	40
41	Income before Income Taxes (line 30 minus line 40)**	292,292	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 292,292	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-Canton

0041798

Report Period Beginning: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,955	2,125	\$ 58,747	\$ 27.65	1
2	Assistant Director of Nursing	3,094	3,364	90,044	26.77	2
3	Registered Nurses	10,813	11,755	270,748	23.03	3
4	Licensed Practical Nurses	17,846	19,401	408,567	21.06	4
5	CNAs & Orderlies	56,803	61,752	632,871	10.25	5
6	CNA Trainees					6
7	Licensed Therapist	5,238	5,238	198,311	37.86	7
8	Rehab/Therapy Aides	7,981	9,446	210,762	22.31	8
9	Activity Director					9
10	Activity Assistants	6,006	6,531	68,543	10.50	10
11	Social Service Workers	3,783	4,088	69,661	17.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,413	21,113	183,528	8.69	15
16	Dishwashers					16
17	Maintenance Workers	1,617	1,765	35,603	20.17	17
18	Housekeepers	10,932	11,886	106,490	8.96	18
19	Laundry	3,977	4,313	31,733	7.36	19
20	Administrator	2,040	2,040	58,853	28.85	20
21	Assistant Administrator	107	107	3,099	28.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,333	11,378	163,940	14.41	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	1,947	2,121	27,157	12.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,885	178,423	\$ 2,618,657 *	\$ 14.68	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	21,800	9, 13	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)		\$ 21,800		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland Health Care Center-Canton

0041798

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jill Centko	Administrator	0	\$ 58,853	Workers' Compensation Insurance	\$ 122,989	IDPH License Fee	\$ 1,098		
Jill Centko	Asst Admin	0	3,099	Unemployment Compensation Insurance	39,245	Advertising: Employee Recruitment	2,396		
				FICA Taxes	185,542	Health Care Worker Background Check	4,449		
				Employee Health Insurance	223,127	(Indicate # of checks performed <u>222</u>)			
				Employee Meals		Dues / Subs	976		
				Illinois Municipal Retirement Fund (IMRF)*		Association	3,019		
				401K	13,963	ND Association	4,333		
				Other	7,491	Advertising	73,864		
				Disability	6,022				
				Employee Uniform	3,782	Less Lobbying Expenses	(7,448)		
				Home Office Allocation	38,066	Less: Public Relations Expense	()		
				P/R O/H	(2)	Non-allowable advertising	(71,202)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 61,952	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,485	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Home Office Allocation			\$ 275,599				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)					
C. Professional Services									
Vendor/Payee	Type		Amount						
Claudon, Kost, Barnhrt, Beal	Legal		\$ 2,415				In-State Travel	13,915	
Elvidge Kelley Attorney	Legal		4,661				Includes travel expenses to the home offices in Toledo, OH for regional meeting		
Holland & Knight LLP	Legal		2,051				Seminar Expense		
Various	Accounting		46						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
			\$ 9,173				TOTAL	\$ 13,915	

* Attach copy of IMRF notifications

**See instructions.

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 \$2274
- (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? IHCA \$943 Alliance \$2172
- (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. \$ 37,982 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. \$ 45,627
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. \$ 277
- (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 \$5,000, 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.