

		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: 0041814

Facility Name: Heartland Health Care Center-Henry

Address: 1650 Indian Town Road Henry 61537
 Number City Zip Code

County: Marshall

Telephone Number: (309) 364-3905 **Fax #** (309) 364-2247

HFS ID Number: 344402510013

Date of Initial License for Current Owners: 10/10/1988

Type of Ownership:

<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-Henry

0041814 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 _____

	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>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</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>94</u>	TOTALS	<u>94</u>	<u>34,310</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>2,625</u>	<u>13,190</u>	<u>8,275</u>	<u>24,090</u>	8
9	SNF/PED					9
10	ICF	<u>875</u>	<u>3,742</u>	<u>381</u>	<u>4,998</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,500</u>	<u>16,932</u>	<u>8,656</u>	<u>29,088</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.78%

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 4/1/1989

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/1/1989 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 66 and days of care provided 7,377

Medicare Intermediary National Government Services (formerly Administar)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 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	202,494	12,917	7,709	223,120	1,674	224,794		224,794		1
2	Food Purchase		150,959		150,959		150,959	(4,730)	146,229		2
3	Housekeeping	69,068	9,028	1,096	79,192		79,192		79,192		3
4	Laundry	49,450	12,979		62,429		62,429		62,429		4
5	Heat and Other Utilities			124,491	124,491	3,839	128,330	(4,401)	123,929		5
6	Maintenance	50,641	11,116	27,636	89,393		89,393		89,393		6
7	Other (specify):*			613	613		613		613		7
8	TOTAL General Services	371,653	196,999	161,545	730,197	5,513	735,710	(9,131)	726,579		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,438,808	99,567	41,069	1,579,444	3,103	1,582,547	(12,297)	1,570,250		10
10a	Therapy	446,955	27	144,929	591,911		591,911	(540)	591,371		10a
11	Activities	48,506	3,660	3,152	55,318		55,318	(1)	55,317		11
12	Social Services	83,545	286	128	83,959		83,959		83,959		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,017,814	103,540	207,278	2,328,632	3,103	2,331,735	(12,838)	2,318,897		16
	C. General Administration										
17	Administrative	83,174		284,104	367,278	(60,019)	307,259		307,259		17
18	Directors Fees										18
19	Professional Services			3,365	3,365		3,365	(887)	2,478		19
20	Dues, Fees, Subscriptions & Promotions			64,636	64,636		64,636	(51,831)	12,805		20
21	Clerical & General Office Expenses	156,524	36,569	118,161	311,254		311,254	(97,233)	214,021		21
22	Employee Benefits & Payroll Taxes			485,824	485,824	39,242	525,066		525,066		22
23	Inservice Training & Education			987	987		987		987		23
24	Travel and Seminar			6,805	6,805		6,805		6,805		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			117,848	117,848		117,848		117,848		26
27	Other (specify):*										27
28	TOTAL General Administration	239,698	36,569	1,081,730	1,357,997	(20,777)	1,337,220	(149,951)	1,187,269		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,629,165	337,108	1,450,553	4,416,826	(12,161)	4,404,665	(171,920)	4,232,745		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Henry #0041814 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			239,080	239,080	11,824	250,904		250,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,345	4,345	337	4,682		4,682			32
33	Real Estate Taxes			106,392	106,392		106,392	14,257	120,649			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,965	60,965		60,965		60,965			35
36	Other (specify):*											36
37	TOTAL Ownership			410,782	410,782	12,161	422,943	14,257	437,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,486	14	202,500		202,500		202,500			39
40	Barber and Beauty Shops			13,442	13,442		13,442		13,442			40
41	Coffee and Gift Shops	35,423			35,423		35,423		35,423			41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*		12,135	26,727	38,862		38,862		38,862			43
44	TOTAL Special Cost Centers	35,423	214,621	91,648	341,692		341,692		341,692			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,664,588	551,729	1,952,983	5,169,300		5,169,300	(157,663)	5,011,637			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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	(4,730)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,401)	5		5
6	Rented Facility Space	(1,350)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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)	(78)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28)	21		18
19	Entertainment				19
20	Contributions	(2,972)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(887)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,989)	21		24
25	Fund Raising, Advertising and Promotional	(6,540)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	14,257	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(40,747)	20		28
29	Other-Attach Schedule	(19,198)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,663)		\$	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))	\$ (157,663)		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-Henry

ID# 0041814

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Amor-Fav Financing	\$ (540)	10a	1
2	AR Sub Fee	(4,544)	20	2
3	Med Trans Rev	(10,672)	10	3
4	Med Trans Exp	(1,547)	10	4
5	PS Pysician	(1,894)	21	5
6	Activities Income	(1)	11	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	(19,198)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	(4,730)	0	0	0	0	0	0	0	0	0	0	(4,730)	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	(4,401)	0	0	0	0	0	0	0	0	0	0	(4,401)	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	(9,131)	0	0	0	0	0	0	0	0	0	0	(9,131)	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	(12,297)	0	0	0	0	0	0	0	0	0	0	(12,297)	10
10a	Therapy	(540)	0	0	0	0	0	0	0	0	0	0	(540)	10a
11	Activities	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(12,838)	0	0	0	0	0	0	0	0	0	0	(12,838)	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	(887)	0	0	0	0	0	0	0	0	0	0	(887)	19
20	Fees, Subscriptions & Promotions	(51,831)	0	0	0	0	0	0	0	0	0	0	(51,831)	20
21	Clerical & General Office Expenses	(97,233)	0	0	0	0	0	0	0	0	0	0	(97,233)	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	(149,951)	0	0	0	0	0	0	0	0	0	0	(149,951)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(171,920)	0	0	0	0	0	0	0	0	0	0	(171,920)	29

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07 Ending:

Summary B

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	14,257	0	0	0	0	0	0	0	0	0	0	14,257	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	14,257	0	14,257	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)	(157,663)	0	(157,663)	45									

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	\$ 284,104	HCR ManorCare, Inc.	100.00%	\$ 284,104	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	26,128	Heartland Management Services	100.00%	26,128		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 310,232			\$ 310,232	\$ *	14

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/07 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-Henry

0041814

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	\$ 4,979,418	\$ 106	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	1,061,370	577,717	4,979,418	1,568	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	497,772	4,979,418	881	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,002,556	4,979,418	2,958	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		4,979,418	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,100,636	1,287,391	4,979,418	3,103	6
7	17	Gen'l & Administrative-Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	41,222,846	32,327,667	4,979,418	72,953	7
8	17	Gen'l & Administrativ -Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	102,324,370	42,519,840	4,979,418	151,133	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	7,830,100	4,979,418	13,857	9	
10	22	Employ Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	17,187,062	4,979,418	25,385	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		4,979,418	0	11	
12	30	Depreciation - Polled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	8,005,430	4,979,418	11,824	12	
13									13	
14	32	Interest				3,167,921		337	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	\$ 284,105	25	

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	National City Bank, Trustee		X	Finance Capital Addition	n/a		\$ 81,733	\$		\$ 4,345	1									
2											2									
3											3									
4											4									
5				Interest						337	5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 81,733	\$			\$ 4,682	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 81,733	\$			\$ 4,682	15									

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-Henry COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0041814

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>03-09-326-001</u>	<u>See Attached</u>	\$ <u>106,392.36</u>	\$ <u>106,392.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>106,392.36</u>	\$ <u>106,392.36</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-Henry

0041814

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1988	1988	\$ 1,748,953	\$ 53,363		\$ 53,363	\$	\$ 896,231	4
5	1			2005	342,188						5
6		7/1/06 CAPITAL RATE ADJUST #5		2005	43,364						6
7											7
8											8
		Improvement Type**									
9		CURRENT YEAR DEPRECIATION				98,795		98,795		879,209	9
10		Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)		1988	(161,519)						10
11		Land/Bldg Improvement (See attached schedule)		1988	487,372						11
12		Door Monitor		1989	2,438						12
13		Land/Bldg. Improvement (See attached schedule)		1990	242						13
14		Land/Bldg. Improvement (See attached schedule)		1991	9,067						14
15		Land/Bldg. Improvement (See attached schedule)		1992	8,628						15
16		Land/Bldg. Improvement (See attached schedule)		1993	19,910						16
17		Move Const Cost From CIP		1993	46,289						17
18		7/1/03 Audit Adj (#1) - Constr Cost		1993	(46,289)						18
19		Land/Bldg. Improvement (See attached schedule)		1994	3,550						19
20		Land/Bldg. Improvement (See attached schedule)		1995	7,068						20
21		(24) DOORS		1996	1,136						21
22		ADDITIONAL COST WALLCOVERING		1996	19						22
23		CARPET		1996	863						23
24		HVAC UPGRADE		1996	2,946						24
25		SEWER LINE CONNECTION		1996	2,398						25
26		SANITARY SEWER		1996	13,155						26
27		SEALCOAT & STRIPE PARKING LOT		1996	3,114						27
28		WALLCOVERING		1997	9,801						28
29		WALLCOVERING		1997	9,019						29
30		PAINTING & WALLCOVERING		1997	13,132						30
31		CROWN MOLDING FOR RENOVATION		1997	198						31
32		CARPET & WALLCOVERING		1997	3,245						32
33		VINYL WALL COVERING FROM INVENTORY		1997	343						33
34		ADDL'T COST FOR HOT WATER		1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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	
37	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADD'L CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,948,456	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	70

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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		\$ 2,948,456	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	1
2	<u>PAINING FOR RESIDENTS ROOMS</u>	2000	3,000						2
3	<u>DOOR HARDWARE</u>	2000	906						3
4	<u>PAINING</u>	2000	730						4
5	<u>PAINING</u>	2000	3,000						5
6	<u>DRYWALL</u>	2000	(3,000)						6
7	<u>SMOKE DAMPERS</u>	2000	7,280						7
8	<u>ADDL'T COST SMOKE DAMPERS</u>	2000	658						8
9	<u>TOTAL DOORS</u>	2000	73						9
10	<u>WALLCOVERING</u>	2000	610						10
11	<u>WALLCOVERING</u>	2000	170						11
12	<u>WALLCOVERING</u>	2000	709						12
13	<u>WALLCOVERING</u>	2000	519						13
14		2000	299						14
15	<u>CEILING</u>								15
16	<u>CUSTOM WORKSTATION</u>	2001	1,225						16
17	<u>PAINT & WALLCOVERING</u>	2001	2,067						17
18	<u>WALLCOVERING - LOUNGE RENOVATION</u>	2001	1,760						18
19	<u>WINDOWS</u>	2001	557						19
20	<u>HOT WATER HEATERS</u>	2001	855						20
21	<u>DRAPES</u>	2001	7,900						21
22	<u>CARPET</u>	2001	2,980						22
23	<u>ADDTL COSTS FOR CARPET</u>	2001	29,586						23
24	<u>CARPET</u>	2001	2,260						24
25	<u>WALLCOVERING</u>	2001	500						25
26	<u>WALLCOVERING</u>	2001	516						26
27	<u>CARPENTRY - LOUNGE RENOVATION</u>	2001	90						27
28	<u>DRAPES, SHADES, BLINDS - LOUNGE RENOVATION</u>	2001	6,002						28
29	<u>CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION</u>	2001	1,109						29
30	<u>PAINING, WALLCOVERING - LOUNGE RENOVATION</u>	2001	10,360						30
31	<u>PLUMBING - LOUNGE RENOVATION</u>	2001	9,691						31
32	<u>CONCRETE</u>	2001	4,425						32
33		2001	2,248						33
34	TOTAL (lines 1 thru 33)		\$ 3,047,541	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	34

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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		\$ 3,047,541	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,268,248	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	34

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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		\$ 3,268,248	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,528,481	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	34

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

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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		\$ 3,528,481	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						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)		\$ 3,621,868	\$ 152,158		\$ 152,158	\$	\$ 1,775,440	34

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

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/07 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	\$ 1,384,934	\$ 86,922	\$ 86,922	\$		\$ 1,100,243	71
72	Current Year Purchases	126,340						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			11,824	11,824			74
75	TOTALS	\$ 1,511,274	\$ 86,922	\$ 98,746	\$ 11,824		\$ 1,100,243	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)	\$	5,307,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	239,080	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	250,904	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	11,824	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,875,683	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:	<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: \$ 60,965 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	4978 hrs	\$ 173,535	1,355	\$ 33,872	\$ (600)	6,333	\$ 206,807	1
2	Licensed Speech and Language Development Therapist	10a	743 hrs	25,884	2,027	50,664	3	2,770	76,551	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7101 hrs	247,536	2,403	60,087	624	9,504	308,247	4
5	Physician Care	10,3	visits		76	1,894		76	1,894	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts		130	3,261		130	3,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray	39,3			1,449	36,220		1,449	36,220	13
14	TOTAL			\$ 446,955	7,440	\$ 185,998	\$ 27	20,262	\$ 632,980	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland Health Care Center-Henry# 0041814Report 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	\$ 14,188	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	707,665		3
4	Supply Inventory (priced at)	33,728		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	746		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 756,327	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	3,621,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,511,274		16
17	Accumulated Depreciation (book methods)	(2,875,686)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	44,766		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,476,221	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,232,548	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 53,639	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,885		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,392		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		65,057		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 481,973	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,733		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	26,839		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 108,572	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 590,545	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,642,003	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,232,548	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,736,878	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,736,878	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,332,009	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,332,009	17
B. Transfers (Itemize):			
18	Change in Interdivision	(1,426,884)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,426,884)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,642,003	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

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	\$ 4,803,957	1
2	Discounts and Allowances for all Levels	(2,535)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,801,422	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,400,817	6
7	Oxygen	15,831	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,416,648	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	1,802	12
13	Barber and Beauty Care	18,346	13
14	Non-Patient Meals	3,006	14
15	Telephone, Television and Radio	(4)	15
16	Rental of Facility Space	1,350	16
17	Sale of Drugs	223,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,911	19
20	Radiology and X-Ray	833	20
21	Other Medical Services	16,158	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 280,874	23
D. Non-Operating Revenue			
24	Contributions	2,372	24
25	Interest and Other Investment Income***	(7)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,365	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)	\$ 6,501,309	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	730,197	31
32	Health Care	2,328,632	32
33	General Administration	1,357,997	33
B. Capital Expense			
34	Ownership	410,782	34
C. Ancillary Expense			
35	Special Cost Centers	341,692	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)*	\$ 5,169,300	40
41	Income before Income Taxes (line 30 minus line 40)**	1,332,009	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,332,009	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heartland Health Care Center-Henry

0041814

Report Period Beginning:

01/01/07

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	1,983	2,184	\$ 68,065	\$ 31.17	1
2	Assistant Director of Nursing	1,726	1,901	37,920	19.95	2
3	Registered Nurses	13,523	14,894	315,476	21.18	3
4	Licensed Practical Nurses	18,606	20,493	358,592	17.50	4
5	CNAs & Orderlies	55,751	61,403	633,878	10.32	5
6	CNA Trainees					6
7	Licensed Therapist	5,349	5,349	186,451	34.86	7
8	Rehab/Therapy Aides	9,808	11,354	260,504	22.94	8
9	Activity Director					9
10	Activity Assistants	8,764	9,654	83,929	8.69	10
11	Social Service Workers	5,803	6,334	83,545	13.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,856	21,891	202,494	9.25	15
16	Dishwashers					16
17	Maintenance Workers	3,233	3,566	50,641	14.20	17
18	Housekeepers	7,529	8,297	69,068	8.32	18
19	Laundry	5,404	5,959	49,450	8.30	19
20	Administrator	2,250	2,250	83,174	36.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,011	11,402	156,524	13.73	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	1,447	1,595	24,877	15.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,043	188,526	\$ 2,664,588 *	\$ 14.13	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	18,000	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,261	5,10,3	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)		\$ 21,261		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland Health Care Center-Henry

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 \$2158
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes \$3391
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? yes If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,007 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
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. \$ yes Has any meal income been offset against related costs? no Indicate the amount. \$ (3,006)
- (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.