

		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:** 0041822

**Facility Name:** Heartland Health Care Center-Macomb

**Address:** 8 Doctor Lane Macomb 61455  
 Number City Zip Code

**County:** McDonough

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

**HFS ID Number:** 344402510009

**Date of Initial License for Current Owners:** 1966

**Type of Ownership:**

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

**In the event there are further questions about this report, please contact:**  
**Name:** Craig Dekany **Telephone Number:** (419) 252-5740

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry A. Lazarus</u>	
	(Title) <u>Vice-President Reimbursement</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

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

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822 Report Period Beginning: 1-1-07 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	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	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		10,336	10,385	20,721	8
9	SNF/PED					9
10	ICF	4,076			4,076	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,076	10,336	10,385	24,797	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.92%

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 80 and days of care provided 9,300

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-Maccomb # 0041822 Report Period Beginning: 1-1-07 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	
	<b>A. General Services</b>											
1	Dietary	173,080	13,021	8,027	194,128	1,531	195,659		195,659			1
2	Food Purchase		138,498		138,498		138,498	(25,108)	113,390			2
3	Housekeeping	80,786	12,299		93,085		93,085		93,085			3
4	Laundry	39,739	7,761	98	47,598		47,598		47,598			4
5	Heat and Other Utilities			107,937	107,937	3,512	111,449	(3,792)	107,657			5
6	Maintenance	39,414	8,679	44,883	92,976		92,976		92,976			6
7	Other (specify):*			896	896		896		896			7
8	<b>TOTAL General Services</b>	<b>333,019</b>	<b>180,258</b>	<b>161,841</b>	<b>675,118</b>	<b>5,043</b>	<b>680,161</b>	<b>(28,900)</b>	<b>651,261</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	1,270,859	111,636	26,798	1,409,293	2,838	1,412,131	(4,198)	1,407,933			10
10a	Therapy	419,578	11,225	171,413	602,216		602,216	(474)	601,742			10a
11	Activities	42,424	4,660	2,016	49,100		49,100		49,100			11
12	Social Services	75,191		1,981	77,172		77,172		77,172			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,808,052</b>	<b>127,521</b>	<b>207,608</b>	<b>2,143,181</b>	<b>2,838</b>	<b>2,146,019</b>	<b>(4,672)</b>	<b>2,141,347</b>			16
	<b>C. General Administration</b>											
17	Administrative	64,587		261,981	326,568	(56,990)	269,578		269,578			17
18	Directors Fees											18
19	Professional Services			84	84	(84)						19
20	Dues, Fees, Subscriptions & Promotions			72,950	72,950		72,950	(53,982)	18,968			20
21	Clerical & General Office Expenses	132,635	40,798	43,917	217,350	84	217,434	(20,130)	197,304			21
22	Employee Benefits & Payroll Taxes			439,598	439,598	35,898	475,496		475,496			22
23	Inservice Training & Education			846	846		846		846			23
24	Travel and Seminar			12,478	12,478		12,478		12,478			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,561	100,561		100,561		100,561			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>197,222</b>	<b>40,798</b>	<b>932,415</b>	<b>1,170,435</b>	<b>(21,092)</b>	<b>1,149,343</b>	<b>(74,112)</b>	<b>1,075,231</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,338,293</b>	<b>348,577</b>	<b>1,301,864</b>	<b>3,988,734</b>	<b>(13,211)</b>	<b>3,975,523</b>	<b>(107,684)</b>	<b>3,867,839</b>			29

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

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

Facility Name & ID Number Heartland Health Care Center-Macomb #0041822 Report Period Beginning: 1-1-07 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
	<b>D. Ownership</b>										
30	Depreciation			224,890	224,890	10,816	235,706		235,706		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			33,281	33,281	2,395	35,676		35,676		32
33	Real Estate Taxes			54,077	54,077		54,077	(97)	53,980		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			20,262	20,262		20,262		20,262		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			332,510	332,510	13,211	345,721	(97)	345,624		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		202,355		202,355		202,355		202,355		39
40	Barber and Beauty Shops			7,674	7,674		7,674		7,674		40
41	Coffee and Gift Shops	8,770			8,770		8,770		8,770		41
42	Provider Participation Fee			43,800	43,800		43,800		43,800		42
43	Other (specify):*		13,902	92,403	106,305		106,305		106,305		43
44	<b>TOTAL Special Cost Centers</b>	8,770	216,257	143,877	368,904		368,904		368,904		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,347,063	564,834	1,778,251	4,690,148		4,690,148	(107,781)	4,582,367		45

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

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning: 1-1-07

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	(25,108)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,792)	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	(115)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(903)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,187)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(688)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,539)	21		24
25	Fund Raising, Advertising and Promotional	(53,982)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(97)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,370)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (107,781)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (107,781)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heartland Health Care Center-Macomb

ID# 0041822

Report Period Beginning: 1-1-07

Ending: 12-31-07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Med Trans, Amb & Trans Expense	\$ (2,896)	10	1
2	Purchased Services PT, OT, Speech	(474)	10a	2
3				3
4				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	<b>Total</b>	(3,370)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,108)	0	0	0	0	0	0	0	0	0	0	(25,108)	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	(3,792)	0	0	0	0	0	0	0	0	0	0	(3,792)	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	<b>TOTAL General Services</b>	<b>(28,900)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(28,900)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,198)	0	0	0	0	0	0	0	0	0	0	(4,198)	10
10a	Therapy	(474)	0	0	0	0	0	0	0	0	0	0	(474)	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	<b>TOTAL Health Care and Programs</b>	<b>(4,672)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,672)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(53,982)	0	0	0	0	0	0	0	0	0	0	(53,982)	20
21	Clerical & General Office Expenses	(20,130)	0	0	0	0	0	0	0	0	0	0	(20,130)	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	<b>TOTAL General Administration</b>	<b>(74,112)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(74,112)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(107,684)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(107,684)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	(97)	0	0	0	0	0	0	0	0	0	0	(97)	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	<b>TOTAL Ownership</b>	<b>(97)</b>	<b>0</b>	<b>(97)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(107,781)</b>	<b>0</b>	<b>(107,781)</b>	<b>45</b>									

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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
Manor Care, Inc	100	Health Care & Retirement Corporation of America	Toledo, OH			
		See H/O Cost Report				

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	\$ 261,981	HCR Manor Care, Inc.	100.00%	\$ 261,981	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	23,391	Heartland Management Services		23,391		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 285,372			\$ 285,372	\$ *	14

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

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 1-1-07 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-Macomb

# 0041822

Report Period Beginning: 1-1-07

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

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

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

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	\$ 4,555,094	\$ 97	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	1,061,370	577,717	4,555,094	1,434	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	497,772		4,555,094	806	3
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,002,556		4,555,094	2,706	4
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.			4,555,094	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,100,636	1,287,391	4,555,094	2,838	6
7	17	Gen'l & Administrative-Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	41,222,846	32,327,667	4,555,094	66,736	7
8	17	Gen'l & Administrativ -Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	102,324,370	42,519,840	4,555,094	138,254	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	7,830,100		4,555,094	12,676	9
10	22	Employ Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	17,187,062		4,555,094	23,222	10
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.			4,555,094	0	11
12	30	Depreciation - Polled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	8,005,430		4,555,094	10,816	12
13										13
14	32	Interest				3,167,921			2,395	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		\$ 261,980	25

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 1-1-07 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	National City Bank, Trustee		X	Finance Capital Additions			\$ 581,402	\$ 581,402			\$ 33,281	1
2												2
3												3
4												4
5	Interest										2,395	5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 581,402	\$ 581,402			\$ 35,676	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 581,402	\$ 581,402			\$ 35,676	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-Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0041822

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>11-300-953-00</u>	<u>See Attached</u>	\$ <u>52,951.22</u>	\$ <u>52,951.22</u>
2. <u>11-300-961-00</u>	<u>See Attached</u>	\$ <u>1,125.60</u>	\$ <u>1,125.60</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>54,076.82</u>	\$ <u>54,076.82</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-Macomb

# 0041822 Report Period Beginning:

1-1-07 Ending:

12-31-07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,692 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

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

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1983&amp;2003</u>	<u>\$ 105,511</u>	1
2			<u>2005</u>	<u>734</u>	2
3	<b>TOTALS</b>			<b>\$ 106,245</b>	3

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	58		1983	1983	\$ 824,586	\$ 31,169		\$ 31,169	\$	\$ 953,132	4
5	6			2001	404,817						5
6		AUDIT ADJ 7/1/03 (#1)		2001	(55,875)						6
7	16			2003	726,962						7
8		AUDIT ADJ 7/1/06 (#17)		2003	56,765						8
		Improvement Type**									
9		Building Improvements (Current Year Depreciation)				126,364		126,364		1,264,443	9
10		Land Improvements		1983	19,035						10
11		Land Improvements - Audit Adj 7/1/03 (#7) - Chg Yr		1983	300						11
12		Building Improvements		1984	15,076						12
13		Building Improvements		1985	20,813						13
14		Building Improvements		1986	42,783						14
15		Land Improvements		1986	3,741						15
16		Adjust HGCC Purchase		1986	(60,000)						16
17		Audit Adj 7/1/03 (#2) - Pg 12, Line 16		1986	60,000						17
18		Building Improvements		1987	70,097						18
19		Interior Renovation		1987	490						19
20		Audit Adj 7/1/03 (#8) - Pg 12, Line 19		1987	(490)						20
21		Building Improvements		1988	2,068						21
22		Water Heater		1988	732						22
23		Audit Adj 7/1/03 (#3) - Pg 12 Line 22		1988	(732)						23
24		Repair Valve		1988	1,336						24
25		Audit Adj 7/1/03 (#4) - Pg 12 Line 24		1988	(1,336)						25
26		Light Fix-Over Bed		1988	3,770						26
27		Audit Adj 7/1/03 (#5) - Pg 12 Line 26		1988	(3,770)						27
28		Land Improvements		1989	1,614						28
29		Building Improvements		1989	25,315						29
30		Storage Shed		1990	4,980						30
31		Audit Adj 7/1/03 (#6) - Pg 12 Line 30		1990	(4,980)						31
32		Land Improvements		1990	950						32
33		Building Improvements		1990	11,382						33
34		Building (Bldg)		1990	3,186						34
35		Audit Adj 7/1/03 (#9) - Pg 12, Line 34		1990	(3,186)						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

Ending:

12-31-07

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Building Improvements	1991	\$ 5,547	\$		\$	\$	37	
38	Building Improvements	1992	10,800					38	
39	Land Improvements	1993	23,517					39	
40	Building Improvements	1993	13,585					40	
41	Building Improvements	1994	51,433					41	
42	Land Improvements	1995	4,302					42	
43	Building Improvements	1995	121,882					43	
44	SMOKE DAMPER	1996	853					44	
45	WALLCOVERING	1996	358					45	
46	TILE	1996	5,333					46	
47	PLUMBING FOR BEAUTY SHOP	1996	3,735					47	
48	CABINETS IN PERSONAL CARE	1996	2,450					48	
49	ELECTRICAL WIRING FOR PERSONAL	1996	1,740					49	
50	TILE FLOOR	1996	824					50	
51	ADDITIONAL COST TILE FLOOR	1996	189					51	
52	PAINT	1996	1,025					52	
53	ADDITIONAL COST A/C (DUCTWORK)	1996	262					53	
54	CARPET	1996	846					54	
55	COUNTERTOP	1996	894					55	
56	PAINTING	1996	1,172					56	
57	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278					57	
58	HVAC	1996	600					58	
59	WALLCOVERING	1996	2,112					59	
60	FLOORING	1996	514					60	
61	ADDITIONAL WALLCOVERING	1996	6					61	
62	WALLCOVERING	1996	382					62	
63	CONCRETE	1996	8,812					63	
64	PAVING	1996	7,710					64	
65	PAVING	1996	13,835					65	
66	RENOVATION CHARGES (DUMPSTER)	1996	210					66	
67	PAVING-AUDIT ADJ 7/1/03 (#10) - CHG YR	1996	2,652					67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 2,458,287	\$ 157,533		\$ 157,533	\$	2,217,575	70

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,458,287	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	ANGLE BRACKETS FOR HANDRAIL	1997	700						2
3	WALLCOVERING	1997	599						3
4	HANDRAIL	1997	10,069						4
5	PAINTING & WALLCOVERING	1997	15,003						5
6	PAINTING	1997	2,500						6
7	ADDITIONAL COST FOR HANDRAIL	1997	1,480						7
8	COVE BASE	1997	671						8
9	WALL PROTECTION	1997	2,192						9
10	PAINTING & WALLCOVERING	1997	18,964						10
11	(2) NURSES STATION SYSTEMS	1997	11,176						11
12	WALLCOVERING	1997	24						12
13	ELECTRICAL WIRING. OUTLETS & T	1997	3,420						13
14	PAINTING, WALLCOVERING & COVE	1997	19,206						14
15	ADDLT COST FOR A/C	1997	105						15
16	NURSES STATION SYSTEM	1997	4,625						16
17	RENOVATE SHOWER ROOM	1997	939						17
18	A/C HEAT	1997	15,762						18
19	ROOF	1997	3,444						19
20	RENOVATE CENTRAL BATH	1997	2,475						20
21	PLUMBING IN KITCHEN	1997	1,102						21
22	ADDL'T COST FOR A/C	1997	105						22
23	VINLY WALL COVERING FROM INVENTORY	1997	2,425						23
24	HVAC	1997	682						24
25	ADDL'T COST FOR GENERATOR	1997	2,233						25
26	NURSES STATION SYSTEM	1997	1,600						26
27	CABINETS FOR BKKPG & MED RECOR	1997	5,432						27
28	HVAC (ADDL'T COST)	1997	880						28
29	ADDL'T RENOVATION COST	1997	28						29
30	REMODEL BOOKKEEPING OFFICE	1997	150						30
31	ADDL'T GENERATOR COST	1997	120						31
32	CARPET	1997	737						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,587,135	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

Ending:

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**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,587,135	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	DRYWALL	1997	2,750						2
3	PERIMETER ALARM SYSTEM	1997	5,972						3
4	WALLCOVERING	1997	651						4
5	SIDEWALKS	1997	5,875						5
6	Ceiling Tile For Nurses Station	1998	1,446						6
7	Additional Cost for Tile Floor	1998	291						7
8	Wallcovering	1998	414						8
9	Misc Labor & Materials for Gutters	1998	215						9
10	Excavation of Ditch & Storm Sewers	1998	975						10
11	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						11
12	ELECTRICAL WIRING	1998	665						12
13	ADDL'T COST ON FLOORING	1998	16						13
14	ADDL'T COST FOR COUNTERTOPS	1998	604						14
15	TILE FLOOR	1998	704						15
16	CUMMINS/ONAN GENERATOR	1998	24,882						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						17
18	FIRE ALARM CONTROL PANEL	1998	7,925						18
19	A/C HEAT ROOF	1998	672						19
20	GENERATOR	1998	303						20
21	FIRE ALARM SYSTEM	1998	17,066						21
22	GENERATOR	1998	25,364						22
23	HVAC RENOVATION	1998	646						23
24	Audit Adj 7/1/03 (#11) - Pg 12C, Line 23	1998	(646)						24
25	HVAC	1998	283,462						25
26	Audit Adj 7/1/03 (#12) - Pg 12C, Line 25	1998	(5,103)						26
27	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						27
28	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						28
29	PAINTING & WALLCOVERING	1999	3,457						29
30	DUCTWORK	1999	467						30
31	RE-KEY FACILITY	1999	779						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,993,418	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,993,418	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	OVERHEAD FROM CONSTRUCTION	1999	4,880						2
3	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 2	1999	(4,880)						3
4	OVERHEAD FROM CONSTRUCTION	1999	27,042						4
5	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 4	1999	(27,042)						5
6	PAINTING	1999	1,245						6
7	EXIT FIXTURES	1999	2,074						7
8	ARMSTRONG FLOORING	1999	443						8
9	SPRINKLER UPGRADE	1999	14,500						9
10	LOCKING DOOR HARDWARE	1999	2,516						10
11	SPRINKLER UPGRADE	1999	14,500						11
12	DOOR LOCKS	1999	1,434						12
13	PLUMBING IN RESTROOMS	1999	1,330						13
14	SPRINKLER UPGRADE	1999	26,084						14
15	EXIT LIGHT	1999	2,074						15
16	FLOW SWITCH FOR SPRINKLER SYST	1999	342						16
17	QUARRY TILE	1999	9,916						17
18	SPRINKLER UPGRADE	1999	5,798						18
19	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 18	1999	(2,900)						19
20	SMOKE DOORS	1999	1,184						20
21	HVAC	1999	1,557						21
22	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						22
23	DOORS AND DOOR OPENERS	1999	3,500						23
24	DOORS AND FRAMES	1999	11,283						24
25	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						25
26	SECURE CARE SYSTEM	1999	15,373						26
27	DOORS	1999	2,750						27
28	DOOR	1999	200						28
29	EXTERIOR DOORS	1999	10,170						29
30	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						30
31	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 30	1999	(2,146)						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,124,941	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,124,941	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	DOOR ALARM	1999	1,475						2
3	SIDEWALKS	1999	9,020						3
4	SMOKING SHELTER	1999	4,950						4
5	PAVING	1999	4,950						5
6	WALLCOVERING	2000	61						6
7	UPGRADE FIRE ALARM SYST	2000	1,121						7
8	CABINETS FOR BUSINESS OFFICE	2000	2,821						8
9	ELECTRICAL FOR BUS OFFICE	2000	375						9
10	ALARM SYSTEM REPAIRS	2000	808						10
11	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						11
12	AUDIT ADJ 7/1/03 (#15) - PG12E, LINE 11	2000	(10,258)						12
13	HVAC	2000	18,151						13
14	HVAC CONSULTANT	2000	1,080						14
15	CARPET	2000	820						15
16	ADDL'T COST COUNTER TOPS	2000	313						16
17	CABINETS	2000	2,391						17
18	CARPET	2000	1,931						18
19	THERMO STAT	2000	1,594						19
20	FRT ON CARPET	2000	72						20
21	SOIL UTILITY RENOVATION	2000	3,240						21
22	SOIL UTILITY RENOVATION	2000	360						22
23	CABINETS/COUNTERTOPS	2000	266						23
24	KITCHEN HVAC	2000	2,017						24
25	SOIL UTILITY RENOVATION	2000	2,640						25
26	DUMPSTER ENCLOSURE	2001	2,457						26
27	WALLCOVERINGS	2001	121						27
28	ADDITIONAL COST PAINTING & VWC	2001	1,238						28
29	PAINTING & VWC	2001	138						29
30	CUSTOM CABINETS	2001	5,289						30
31	INSTALL CARPET	2001	641						31
32	(42) WINDOWS & INSTALLATION	2001	22,328						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,217,609	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,217,609	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						2
3	PAINTING	2001	2,880						3
4	PAINTING	2001	320						4
5	General Constr. - Plumbing	2002	1,236						5
6	Interior Renov. - Wallcoverings	2002	822						6
7	AUDIT ADJ 7/1/03 (#16) - PG12F, LINE 6	2002	(822)						7
8	Interior Renov. - Wallcoverings	2002	44,760						8
9	Interior Renov. - Plumbing	2002	1,394						9
10	Building Addition - Wallcovering	2002	4,077						10
11	Border	2002	154						11
12	Additional Cost - Wallcovering	2002	196						12
13	Additional Cost - Wallcovering	2002	481						13
14	HVAC Electrical & Plumbing	2002	33,930						14
15	HVAC Electrical & Plumbing	2002	3,770						15
16	VWC	2002	496						16
17	Building Addition - Landscaping	2002	1,190						17
18	Building Addition - Landscaping	2002	6,442						18
19	Flooring and VWC	2002	4,823						19
20	Carpeting, Painting and Wallcovering	2003	12,897						20
21	7/1/06 Capital Rate Adj #1	2003	(12,897)						21
22	Developers Costs - Overhead	2003	211,116						22
23	7/1/06 Capital Rate Adj #2	2003	(211,116)						23
24	Architect & Engineering Fees	2003	91,070						24
25	Reproduc, Permit & Plan Fees	2003	15,980						25
26	7/1/06 Capital Rate Adj #3	2003	(5,165)						26
27	7/1/06 Capital Rate Adj #4	2003	(10,815)						27
28	Developers Costs - Interest	2003	16,397						28
29	7/1/06 Capital Rate Adj #5	2003	(16,397)						29
30	Millwork & Electric Service	2003	17,781						30
31	7/1/06 Capital Rate Adj #6	2003	(4,641)						31
32	7/1/06 Capital Rate Adj #7	2003	(13,140)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,417,309	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name &amp; ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12F, Carried Forward</b>		\$ 3,417,309	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	Developers Costs - Overhead	2003	3,196						2
3	7/1/06 Capital Rate Adj #8	2003	(3,196)						3
4	Developers Costs - Interest	2003	276						4
5	7/1/06 Capital Rate Adj #9	2003	(276)						5
6	Carpeting, Painting and Wallcovering	2003	47,947						6
7	Soil & Concrete Testing	2003	3,480						7
8	Water & Sewer Fees	2003	120						8
9	7/1/06 Capital Rate Adj #10	2003	(120)						9
10	Site Work General Contractor	2003	32,561						10
11	7/1/06 Capital Rate Adj #11	2003	(32,561)						11
12	Retro Cost Adjustment	2003	45,504						12
13	7/1/06 Capital Rate Adj #12	2003	(45,504)						13
14	Window Treatments	2003	8,850						14
15	Soil and Concrete Testing (Addtl Costs)	2003	2,110						15
16	7/1/06 Capital Rate Adj #15	2003	(2,110)						16
17	Engineering Fees	2003	9,194						17
18	7/1/06 Capital Rate Adj #16	2003	(9,194)						18
19	Double Egress Door	2004	5,905						19
20	Construction Drawings & Specs	2004	5,998						20
21	Carpetry, Case Work, Painting	2004	37,880						21
22	Retainage for Addition	2005	1,533						22
23	Flooring, Corner Guards	2005	14,903						23
24	7/1/06 Capital Rate Adj #13	2005	(1,455)						24
25	7/1/06 Capital Rate Adj #14	2005	(55)						25
26	Materials to Complete Addition Project	2005	24,280						26
27	Physical Therapy Addn - LI - Soil Testing	2006	3,773						27
28	Physical Therapy Addn - LI - Landscaping	2006	24,893						28
29	Physical Therapy Addn - LI - Permit Fees	2006	5,423						29
30	Physical Therapy Addn - BI - Genl Contracting	2006	428,270						30
31	Physical Therapy Addn - BI - Carpeting	2006	6,948						31
32	Physical Therapy Addn - BI - Electrical	2006	288						32
33	Physical Therapy Addn - BI - Arch & Eng	2006	51,475						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,087,645	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	<b>Totals from Page 12G, Carried Forward</b>		\$ 4,087,645	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	1
2	Physical Therapy Addn - BI - Genl A/H	2006	17,950						2
3	Corr & Main Dining Room - BI - Genl O/H	2006	7,409						3
4	Corr & Main Dining Room - BI - Carpentry	2006	26,688						4
5	Corr & Main Dining Room - BI - Wallcovering	2006	36,561						5
6	HR Office, BB Shop Renovation - BI - Carpet, Wallcovering	2007	6,145						6
7	Fire Safety Caulking	2007	24,060						7
8	Siding and Soffits on Gar	2007	5,100						8
9	Fire Walls and Caulking	2007	24,060						9
10	Cabinets in Beauty Shop	2007	2,982						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,238,600	\$ 157,533		\$ 157,533	\$	\$ 2,217,575	34

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

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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 12H, Carried Forward	\$ 4,238,600	\$ 157,533		\$ 157,533	\$	\$ 2,217,575		1
2									2
3									3
4									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	TOTAL (lines 1 thru 33)	\$ 4,238,600	\$ 157,533		\$ 157,533	\$	\$ 2,217,575		34

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

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 1-1-07 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	\$ 1,126,221	\$ 67,357	\$ 67,357	\$		\$ 867,984	71
72	Current Year Purchases	56,921						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			10,816	10,816			74
75	TOTALS	\$ 1,183,142	\$ 67,357	\$ 78,173	\$ 10,816		\$ 867,984	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van	1986	\$ 20,573	\$	\$	\$		\$ 20,573	76
77		Chair Lift for Van	1990	1,260					1,260	77
78		Running Board for Van	1995	877					877	78
79										79
80	TOTALS			\$ 22,710	\$	\$	\$		\$ 22,710	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,550,697	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 235,706	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,816	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,108,269	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	<b>TOTAL</b>				\$ _____			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: \$ 20,262

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	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

- (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	5261 hrs	\$ 197,795	1,838	\$ 45,946	\$ 3,128	7,099	\$ 246,869	1
2	Licensed Speech and Language Development Therapist	10a	1580 hrs	59,401	235	5,869	176	1,815	65,446	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4319 hrs	162,382	4,784	119,598	7,921	9,103	289,901	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	5,39, 2	# of prescripts			202,355			202,355	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab, EKG, X-Ray	5,39,3								13
14	<b>TOTAL</b>			\$ 419,578	6,857	\$ 373,768	\$ 11,225	18,017	\$ 804,571	14

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

Facility Name & ID Number Heartland Health Care Center-Macomb# 0041822Report Period Beginning: 1-1-07

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 65,130	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	659,324		3
4	Supply Inventory (priced at )	34,033		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 758,487	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	4,238,600		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,205,852		16
17	Accumulated Depreciation (book methods)	(3,108,271)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP, Goodwill</u>	2,986		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,445,412	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,203,899	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 34,565	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	196,495		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,077		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Acc Expenses</u>	37,277		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 322,414	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	581,402		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 581,402	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 903,816	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,300,083	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,203,899	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,258,106</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,258,106</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>802,870</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>802,870</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>(760,893)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(760,893)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,300,083</b>	<b>24</b> *

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

Facility Name & ID Number Heartland Health Care Center-Macomb# 0041822Report Period Beginning: 1-1-07Ending: 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,779,277	1
2	Discounts and Allowances for all Levels	78,541	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,857,818</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,273,406	6
7	Oxygen	2,210	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,275,616</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	326	12
13	Barber and Beauty Care	8,738	13
14	Non-Patient Meals	24,897	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	197,939	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,450	19
20	Radiology and X-Ray	39,698	20
21	Other Medical Services	969	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 358,017</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	688	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 688</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Late Charges</u>	879	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 879</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,493,018</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	675,118	31
32	Health Care	2,143,181	32
33	General Administration	1,170,435	33
<b>B. Capital Expense</b>			
34	Ownership	332,510	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	368,904	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,690,148</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>802,870</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 802,870</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Heartland Health Care Center-Macomb

# 0041822

Report Period Beginning:

1-1-07

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	2,098	2,286	\$ 66,356	\$ 29.03	1
2	Assistant Director of Nursing	3,369	3,671	84,873	23.12	2
3	Registered Nurses	9,549	10,406	217,181	20.87	3
4	Licensed Practical Nurses	18,225	19,861	328,933	16.56	4
5	CNAs & Orderlies	51,107	55,695	546,112	9.81	5
6	CNA Trainees					6
7	Licensed Therapist	5,319	5,319	200,002	37.60	7
8	Rehab/Therapy Aides	7,317	8,373	219,576	26.22	8
9	Activity Director					9
10	Activity Assistants	4,479	4,882	51,194	10.49	10
11	Social Service Workers	4,221	4,571	75,191	16.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,296	16,675	173,080	10.38	15
16	Dishwashers					16
17	Maintenance Workers	2,889	3,149	39,414	12.52	17
18	Housekeepers	8,760	9,548	80,786	8.46	18
19	Laundry	3,393	3,703	39,739	10.73	19
20	Administrator	2,356	2,845	88,428	31.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,530	7,530	108,794	14.45	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	1,912	2,086	27,404	13.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,820	160,600	\$ 2,347,063 *	\$ 14.61	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	5,400	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 5,400		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number Heartland Health Care Center-Macomb

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. ICHA \$2627 Alliance \$3310
- (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 \$4080
- (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. \$ 27,358 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. \$ 43,800  
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. \$ 24,897
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? n/a  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? no  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.