

		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: 0041640

Facility Name: Heartland Health Care Center-Paxton

Address: 1001 East Pells Street Paxton 60957
 Number City Zip Code

County: Ford

Telephone Number: (217) 379-4361 **Fax #** (217) 379-3325

HFS ID Number: 344402510014

Date of Initial License for Current Owners: 10/03/1988

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, CPA **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 of 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-Paxton

0041640 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>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</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>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,715</u>	<u>18,974</u>	<u>11,170</u>	<u>33,859</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,715</u>	<u>18,974</u>	<u>11,170</u>	<u>33,859</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.63%

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 10/03/1988

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

YES Date 04/01/1989 NO

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

YES NO If YES, enter number of beds certified 96 and days of care provided 8,281

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-Paxton # 0041640 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	239,536	22,032	24,375	285,943	2,300	288,243		288,243		1
2	Food Purchase		182,439		182,439		182,439	(8,605)	173,834		2
3	Housekeeping	102,937	11,447	35	114,419		114,419		114,419		3
4	Laundry	36,014	10,421	140	46,575		46,575		46,575		4
5	Heat and Other Utilities			165,767	165,767	5,276	171,043	(10,727)	160,316		5
6	Maintenance	70,664	11,006	59,386	141,056		141,056		141,056		6
7	Other (specify):*			611	611		611		611		7
8	TOTAL General Services	449,151	237,345	250,314	936,810	7,576	944,386	(19,332)	925,054		8
	B. Health Care and Programs										
9	Medical Director			26,400	26,400		26,400		26,400		9
10	Nursing and Medical Records	1,984,850	133,404	104,901	2,223,155	4,264	2,227,419	(27,077)	2,200,342		10
10a	Therapy	570,112	18,533	81,109	669,754		669,754	(555)	669,199		10a
11	Activities	102,308	8,079	3,605	113,992		113,992		113,992		11
12	Social Services	121,331	8	2,987	124,326		124,326		124,326		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,778,601	160,024	219,002	3,157,627	4,264	3,161,891	(27,632)	3,134,259		16
	C. General Administration										
17	Administrative	151,172		392,519	543,691		543,691		543,691		17
18	Directors Fees					(84,566)	(84,566)		(84,566)		18
19	Professional Services			1,305	1,305		1,305		1,305		19
20	Dues, Fees, Subscriptions & Promotions			73,161	73,161		73,161	(48,053)	25,108		20
21	Clerical & General Office Expenses	267,324	51,303	349,401	668,028		668,028	(275,999)	392,029		21
22	Employee Benefits & Payroll Taxes			656,530	656,530	53,929	710,459		710,459		22
23	Inservice Training & Education			5,656	5,656		5,656		5,656		23
24	Travel and Seminar			24,565	24,565		24,565		24,565		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			123,887	123,887		123,887		123,887		26
27	Other (specify):*			2,956	2,956		2,956		2,956		27
28	TOTAL General Administration	418,496	51,303	1,629,980	2,099,779	(30,637)	2,069,142	(324,052)	1,745,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,646,248	448,672	2,099,296	6,194,216	(18,797)	6,175,419	(371,016)	5,804,403		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-Paxton #0041640 Report Period Beginning: 01-01-07 Ending: 12-31-07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			322,618	322,618	16,249	338,867	(16,249)	322,618		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			32,864	32,864	2,548	35,412		35,412		32
33	Real Estate Taxes			73,909	73,909		73,909	869	74,778		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			83,908	83,908		83,908		83,908		35
36	Other (specify):*										36
37	TOTAL Ownership			513,299	513,299	18,797	532,096	(15,380)	516,716		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		277,154	1,180	278,334		278,334		278,334		39
40	Barber and Beauty Shops		1,021	16,295	17,316		17,316		17,316		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee		52,560		52,560		52,560		52,560		42
43	Other (specify):*		92,005	70,637	162,642		162,642		162,642		43
44	TOTAL Special Cost Centers		422,740	88,112	510,852		510,852		510,852		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,646,248	871,412	2,700,707	7,218,367		7,218,367	(386,396)	6,831,971		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-Paxton

0041640

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	(8,605)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,727)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,259)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,528)	21		18
19	Entertainment				19
20	Contributions	(3,009)	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	(266,462)	21		24
25	Fund Raising, Advertising and Promotional	(48,053)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	869	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,622)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (386,396)		\$	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))	\$ (386,396)		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-Paxton

ID# 0041640

Report Period Beginning: 01-01-07

Ending: 12-31-07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-Allowable Therapy PT	\$ (270)	10a	1
2	Non-Allowable Therapy OT	(216)	10a	2
3	Non-Allowable Therapy ST	(69)	10a	3
4	Ambulance and Medical Transportation Expense	(10,929)	10	4
5	Medical Transportation Revenue	(12,889)	10	5
6	SGA Depreciation Allocation	(16,249)	30	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	(40,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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	(8,605)	0	0	0	0	0	0	0	0	0	0	(8,605)	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	(10,727)	0	0	0	0	0	0	0	0	0	0	(10,727)	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	(19,332)	0	0	0	0	0	0	0	0	0	0	(19,332)	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	(27,077)	0	0	0	0	0	0	0	0	0	0	(27,077)	10
10a	Therapy	(555)	0	0	0	0	0	0	0	0	0	0	(555)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(27,632)	0	0	0	0	0	0	0	0	0	0	(27,632)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(48,053)	0	0	0	0	0	0	0	0	0	0	(48,053)	20
21	Clerical & General Office Expenses	(275,999)	0	0	0	0	0	0	0	0	0	0	(275,999)	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	(324,052)	0	0	0	0	0	0	0	0	0	0	(324,052)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(371,016)	0	0	0	0	0	0	0	0	0	0	(371,016)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01-01-07 Ending: 12-31-07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(16,249)	0	0	0	0	0	0	0	0	0	0	(16,249)	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	869	0	0	0	0	0	0	0	0	0	0	869	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	(15,380)	0	(15,380)	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)	(386,396)	0	(386,396)	45									

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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	\$ 392,519	CHR ManorCare, Inc.	100.00%	\$ 392,519	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	28,209	Heartland Management Services	100.00%	28,209		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 420,728			\$ 420,728	\$ *	14

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

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 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-Paxton

0041640

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

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	\$ 6,843,024	\$ 146	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	1,061,370	577,717	6,843,024	2,154	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	497,772	6,843,024	1,211	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,002,556	6,843,024	4,065	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		6,843,024	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	2,100,636	1,287,391	6,843,024	4,264	6
7	17	Gen'l & Administrative-Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	41,222,846	32,327,667	6,843,024	100,256	7
8	17	Gen'l & Administrativ -Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	102,324,370	42,519,840	6,843,024	207,696	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.	7,830,100	6,843,024	19,043	9	
10	22	Employ Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	17,187,062	6,843,024	34,886	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nors. Fac.		6,843,024	0	11	
12	30	Depreciation - Polled	Accumulated Cost	3,371,307,314	369 Nors. Fac.	8,005,430	6,843,024	16,249	12	
13									13	
14	32	Interest				3,167,921		2,548	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	\$ 392,518	25	

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	National City Bank, Trustee		X	Finance Capital Additions	N/A		\$ 618,583	\$ 618,583			\$ 32,864	1					
2												2					
3												3					
4												4					
5	Interest										2,548	5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 618,583	\$ 618,583			\$ 35,412	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 618,583	\$ 618,583			\$ 35,412	15					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 73,040	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 73,909	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 869	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 73,909	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 74,778	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	60,217	8
	2003	60,734	9
	2004	64,120	10
	2005	73,040	11
	2006	73,909	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Paxton COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0041640

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>11-14-008-476-001</u>	<u>See Attached</u>	\$ <u>73,909.00</u>	\$ <u>73,909.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>73,909.00</u>	\$ <u>73,909.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640 Report Period Beginning:

01-01-07 Ending:

12-31-07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,919 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

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

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

n/a

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 75,186</u>	1
2					2
3	TOTALS			\$ 75,186	3

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

Report Period Beginning:

01-01-07

Ending:

12-31-07

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	79		1988	1988	\$ 1,323,187	\$ 129,184		\$ 129,184	\$	\$ 1,532,102	4
5	Audit Adj (#1) - Overhead & Int			1998	1,129,268						5
6	8			2001	440,268						6
7	Audit Adj (#2) - Various			2001	(33,214)						7
8				2004	673,649						8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION										
10	Land/Bldg. Improvement (See attached schedule)			1988	279,229			80,366		798,590	9
11	Additional Attic Insulation			1989	3,500						10
12	Fire Alarm System			1990	294						11
13	Audit Adj (#3) - Fire Alarm System			1990	(294)						12
14	Land/Bldg. Improvement (See attached schedule)			1990	8,348						13
15	Land/Bldg. Improvement (See attached schedule)			1991	6,404						14
16	Land/Bldg. Improvement (See attached schedule)			1992	24,904						15
17	Land/Bldg. Improvement (See attached schedule)			1993	12,778						16
18	Land/Bldg. Improvement (See attached schedule)			1994	1,010						17
19	Land/Bldg. Improvement (See attached schedule)			1995	14,522						18
20	BATHTUB			1996	356						19
21	(7) DOORS			1996	3,896						20
22	WALLCOVERING			1996	1,133						21
23	CARPET & WALLCOVERING			1996	2,199						22
24	CEILING			1997	2,101						23
25	WALLCOVERING			1997	8,139						24
26	WALLCOVERING			1997	22						25
27	CREDIT ON BLD IMP-CNCLD RETAIN			1997	(434)						26
28	WALLCOVERING			1997	13,695						27
29	CARPET			1997	1,081						28
30	WALLCOVERING			1997	1,571						29
31	ENGINEERING AND ARCHITECTURAL FEES			1997	75,055						30
32	Audit Adj (#4) - Various			1997	(22,168)						31
33	(14) PKG AMANA A/C UNITS			1997	9,051						32
34	PAINTING			1997	10,933						33
35	PAINTING & WALLCOVERING			1997	7,933						34
36											35
											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-Paxton

0041640

Report Period Beginning:

01-01-07

Ending:

12-31-07

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSE CALL SYSTEM	1997	\$ 2,561	\$		\$	\$	\$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	293						38
39	VINYL WALL COVERING FROM INVENTORY	1997	187						39
40	VINYL WALL COVERING FROM INVENTORY	1997	814						40
41	CUBICLE CURTAIN TRACK	1997	1,416						41
42	NURSE CALL SYSTEM UPGRADE	1997	2,305						42
43	WALLCOVERING	1997	157						43
44	CROWN MOLDING & CHAIR RAIL	1997	820						44
45	GARAGE WOOD	1997	12,983						45
46	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						46
47	WALLCOVERING	1998	191						47
48	COVE BASE	1998	1,529						48
49	WALLCOVERING	1998	75						49
50	DOOR ALARMS	1998	3,598						50
51	WALLCOVERING	1998	249						51
52	SECURE CARE LOCKS	1998	11,971						52
53	ADDL'T NURSE CALL SYSTEM	1998	1,901						53
54	WALLPAPER FROM CONSTRUCTION	1998	196						54
55	GATE	1998	390						55
56	A/C UNIT	1998	1,925						56
57	HVAC FOR ADDITION	1998	47,008						57
58	AUDIT ADJ (#5) - VARIOUS	1998	(6,158)						58
59	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						59
60	REMOVE OVERHEAD PAGING	1998	338						60
61	WALLCOVERING	1998	7,678						61
62	CABINETRY & COUTNERTOPS	1998	8,240						62
63	CARPENTRY	1998	24,126						63
64	ELECTRICAL WORK	1998	444						64
65	ELECTRICAL WORK	1998	32,894						65
66	LIGHT FIXTURES	1998	1,253						66
67	PLUMBING WORK	1998	711						67
68	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,182,250	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	70

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

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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		\$ 4,182,250	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	1
2	<u>SPRINKLER SYSTEM</u>	1998	45,812						2
3	<u>FIRE ALARM SYSTEM</u>	1998	3,370						3
4	<u>FENCE</u>	1998	6,507						4
5	<u>PAVING</u>	1998	38,079						5
6	<u>CONSTRUCTION AND DESIGN OVERHEAD COST</u>	1999	114,792						6
7	<u>AUDIT ADJ (#6) - OVERHEAD COST</u>	1999	(114,792)						7
8	<u>DIRECT VENT UNIT HEATER</u>	1999	1,556						8
9	<u>SECURE CARE LOCKING SYSTEM</u>	1999	958						9
10	<u>SEAL & STRIPE PARKING LOT</u>	1999	3,136						10
11	<u>EXTERIOR LIGHTING</u>	1999	20,250						11
12	<u>SINK & FAUCET</u>	2000	596						12
13	<u>NURSES STATION</u>	2000	11,790						13
14	<u>COUNTERTOP</u>	2000	1,200						14
15	<u>VCT</u>	2000	1,140						15
16	<u>WATER HEATER</u>	2000	3,780						16
17	<u>NURSES STATION</u>	2000	475						17
18	<u>PAINTING</u>	2000	11,005						18
19	<u>CUSTOM CABINETS</u>	2000	7,091						19
20	<u>INSTALL CARPET</u>	2001	593						20
21	<u>GAZEBO</u>	2001	4,319						21
22	<u>CARPENTRY-ARCADIA RENOV</u>	2001	16,430						22
23	<u>CARPENTRY-ARCADIA RENOV</u>	2001	13,084						23
24	<u>AUDIT ADJ (#7) - CARPENTRY</u>	2001	(1,469)						24
25	<u>LANDSCAPING-ARCADIA RENOV</u>	2002	21,295						25
26	<u>AUDIT ADJ (#2) - TRANSFER TO BUILDING</u>	2002	(21,295)						26
27	<u>PAINTING</u>	2002	7,175						27
28	<u>PAINTING</u>	2002	825						28
29	<u>DRAPES</u>	2002	130						29
30	<u>FLOORING,VINYL WALL COVERING</u>	2002	8,405						30
31	<u>OUTDOOR LIGHTING</u>	2002	1,560						31
32	<u>DOORS</u>	2002	5,900						32
33	<u>HALLWAY PAINT AND BORDER</u>	2002	1,150						33
34	TOTAL (lines 1 thru 33)		\$ 4,397,097	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	34

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

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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		\$ 4,397,097	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	1
2	MDS OFFICE-VINYL WALL COVERING	2003	419						2
3	AUDIT ADJ (#9) - VWC	2003	(25)						3
4	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						4
5	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						5
6	MDS OFFICE-ELECTRIC WORK	2003	1,338						6
7	MDS OFFICE-BORDER	2003	66						7
8	AUDIT ADJ (#10) - BORDER	2003	(4)						8
9	CARPET	2003	1,051						9
10	SNF ADDITION-ARCHITECT COSTS	2003	4,612						10
11	OUTLETS IN DINING ROOM	2003	1,280						11
12	TESTING GEOTECHNICAL	2003	3,519						12
13	ENGINEERING, ARCHITECTURAL FEES	2003	156,819						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(63,267)						14
15	RESILIENT FLOORING	2004	17,087						15
16	7/1/06 CAPITAL RATE ADJUST #1	2004	(137)						16
17	SECURITY DOOR	2004	5,354						17
18	WATER,SEWER,UTILITIES FOR ADDITION	2004	44,792						18
19	7/1/06 CAPITAL RATE ADJUST #2	2004	(44,792)						19
20	VINYL WALL COVERING, FLOORING	2004	12,441						20
21	VINYL WALL COVERING, FLOORING (ADJUSTMENT)	2004	(75)						21
22	MILLWORK	2004	2,815						22
23	NEW ROOF	2004	88,184						23
24	SECURITY DOOR	2005	4,932						24
25	CONCRETE WALK & PAD	2006	558						25
26	5 PTAC UNITS	2006	4,136						26
27	CUSTOM WORKSTATIONS	2006	1,806						27
28	DINING,LOBBY,OFFICE-GENL O/H	2007	6,606						28
29	DINING-CARPENTRY	2007	38,528						29
30	ADMISSIONS-CARPENTRY	2007	10,290						30
31	DINING-WALLCOVERING	2007	3,595						31
32	LOBBY-WALLCOVERING	2007	2,288						32
33	ADMINISTRATOR-WALLCOVERING	2007	855						33
34	TOTAL (lines 1 thru 33)		\$ 4,703,217	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	34

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

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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		\$ 4,703,217	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	1
2	ADMISSIONS-WALLCOVERING	2,007	823						2
3	DINING,LOBBY,OFFICE-INTEREST	2,007	486						3
4	CEILING	2,007	14,580						4
5	CONF RM BIRD LOUNGE	2,006	2,228						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)		\$ 4,721,335	\$ 209,550		\$ 209,550	\$	\$ 2,330,692	34

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

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 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	\$ 1,428,585	\$ 96,819	\$ 96,819	\$		\$ 1,107,325	71
72	Current Year Purchases	85,001						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			16,249	16,249			74
75	TOTALS	\$ 1,513,586	\$ 96,819	\$ 113,068	\$ 16,249		\$ 1,107,325	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)	\$ 6,310,107	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,369	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,618	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,249	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,438,017	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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: \$ 83,908 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.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01-01-07 Ending: 12-31-07

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$ 223,315	694	\$ 17,356	\$	694	\$ 240,671	1
2	Licensed Speech and Language Development Therapist	10a	hrs	61,411	216	5,401		216	66,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	285,386	2,334	58,352		2,334	343,738	4
5	Physician Care		visits							5
6	Dental Care	39,3	visits			1,180			1,180	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				277,154		277,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 570,112	3,244	\$ 82,289	\$ 277,154	3,244	\$ 929,555	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-Paxton# 0041640Report 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	\$ 27,423	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	960,128		3
4	Supply Inventory (priced at)	27,692		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	374		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,015,617	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	4,721,333		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,513,586		16
17	Accumulated Depreciation (book methods)	(3,438,016)		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>CPI</u>	970,064		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,842,153	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,857,770	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 25,872	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	355,167		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,809		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		82,485		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 538,333	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	35,660		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 35,660	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 573,993	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,283,777	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,857,770	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,942,022	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,942,022	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	842,638	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)	\$ 842,638	17
B. Transfers (Itemize):			
18		499,117	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 499,117	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,283,777	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Health Care Center-Paxton

0041640

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	\$ 5,452,622	1
2	Discounts and Allowances for all Levels	77,394	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,530,016	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,962,167	6
7	Oxygen	11,400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,973,567	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,539	12
13	Barber and Beauty Care	20,674	13
14	Non-Patient Meals	8,056	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	349,817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,865	19
20	Radiology and X-Ray	38,570	20
21	Other Medical Services	63,894	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 554,415	23
D. Non-Operating Revenue			
24	Contributions	3,009	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,009	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(2)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (2)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,061,005	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	936,810	31
32	Health Care	3,157,627	32
33	General Administration	2,099,779	33
B. Capital Expense			
34	Ownership	513,299	34
C. Ancillary Expense			
35	Special Cost Centers	510,852	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,218,367	40
41	Income before Income Taxes (line 30 minus line 40)**	842,638	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 842,638	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-Paxton

0041640

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	1,986	2,171	\$ 70,895	\$ 32.66	1
2	Assistant Director of Nursing	4,481	4,897	133,157	27.19	2
3	Registered Nurses	12,939	14,140	332,225	23.50	3
4	Licensed Practical Nurses	27,022	29,531	606,578	20.54	4
5	CNAs & Orderlies	72,430	79,156	878,178	11.09	5
6	CNA Trainees					6
7	Licensed Therapist	8,773	8,773	309,886	35.32	7
8	Rehab/Therapy Aides	8,141	10,004	260,226	26.01	8
9	Activity Director					9
10	Activity Assistants	8,211	8,996	102,308	11.37	10
11	Social Service Workers	7,198	7,851	121,331	15.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,591	22,570	239,536	10.61	15
16	Dishwashers					16
17	Maintenance Workers	4,254	4,660	70,664	15.16	17
18	Housekeepers	9,340	10,234	102,937	10.06	18
19	Laundry	3,942	4,325	36,014	8.33	19
20	Administrator	2,278	3,051	126,158	41.35	20
21	Assistant Administrator	2,288	2,288	56,984	24.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,863	11,863	176,429	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,591	1,742	22,742	13.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	207,328	226,252	\$ 3,646,248 *	\$ 16.12	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	26,400	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,400		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

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 \$3152 Alliance \$2544
- (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 \$3468
- (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. \$ 39,926 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. \$ 52,560
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. \$ 8,056
- (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.