

Facility Name & ID Number Heartland Manor Nursing Center

0002923 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 04/01/09

	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	99	Skilled (SNF)	81	34,497	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	99	TOTALS	81	34,497	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	962	1,088	1,448	3,498	8
9	SNF/PED					9
10	ICF	9,304	6,327		15,631	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,266	7,415	1,448	19,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.45%

#REF!

D. How many bed-hold days during this year were paid by the Department? None (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)

Meals on Wheels

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 12/16/1964

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 57 and days of care provided 1,448

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

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	192,683	13,406	4,896	210,985			210,985		1	
2	Food Purchase		104,387		104,387		(11,976)	92,411		2	
3	Housekeeping	67,244	13,577	266	81,087		(17,753)	63,334		3	
4	Laundry	62,093	8,203	748	71,044			71,044		4	
5	Heat and Other Utilities			94,133	94,133			94,133		5	
6	Maintenance	51,592	5,654	35,077	92,323			92,323		6	
7	Other (specify):* Waste Removal			8,827	8,827			8,827		7	
8	TOTAL General Services	373,612	145,227	143,947	662,786		(29,729)	633,057		8	
	B. Health Care and Programs										
9	Medical Director			3,375	3,375			3,375		9	
10	Nursing and Medical Records	982,649	123,549	3,315	1,109,513			1,109,513		10	
10a	Therapy			103,880	103,880			103,880		10a	
11	Activities	47,105	3,605	3,010	53,720			53,720		11	
12	Social Services	16,691		3,010	19,701			19,701		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,046,445	127,154	116,590	1,290,189			1,290,189		16	
	C. General Administration										
17	Administrative	53,193			53,193			53,193		17	
18	Directors Fees									18	
19	Professional Services			69,120	69,120		895	70,015		19	
20	Dues, Fees, Subscriptions & Promotions			18,856	18,856		(2,720)	16,136		20	
21	Clerical & General Office Expenses	108,544	10,101	24,988	143,633			143,633		21	
22	Employee Benefits & Payroll Taxes			291,431	291,431			291,431		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			5,863	5,863		(241)	5,622		24	
25	Other Admin. Staff Transportation			1,334	1,334			1,334		25	
26	Insurance-Prop.Liab.Malpractice			105,874	105,874			105,874		26	
27	Other (specify):*									27	
28	TOTAL General Administration	161,737	10,101	517,466	689,304		(2,066)	687,238		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,581,794	282,482	778,003	2,642,279		(31,795)	2,610,484		29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. #REF!
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			83,091	83,091	83,091		83,091				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,387	17,387	17,387	(4,201)	13,186				32
33	Real Estate Taxes			6,422	6,422	6,422	(6,422)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,388	5,388	5,388		5,388				35
36	Other (specify):*											36
37	TOTAL Ownership			112,288	112,288	112,288	(10,623)	101,665				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,611	3,300	58,911	58,911		58,911				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,746	51,746	51,746		51,746				42
43	Other (specify):* Non-allowable cost			41,119	41,119	41,119	(41,119)					43
44	TOTAL Special Cost Centers		55,611	96,165	151,776	151,776	(41,119)	110,657				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,581,794	338,093	986,456	2,906,343	2,906,343	(83,537)	2,822,806				45

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

** See schedule of adjustments attached at end of cost report.

#REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/08

Ending: 06/30/09

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,441)	43		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	(4,201)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,497)	43		24
25	Fund Raising, Advertising and Promotional	(13,115)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(252)	43		28
29	Other-Attach Schedule See PG5A	(41,996)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,537)		\$	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)	\$ (83,537)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

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Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 7/1/2008

Ending: 6/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	\$ (3,814)	43	1
2	Non Care Real Estate Taxes	(6,422)	33	2
3	Revenue Offset to Housekeeping	(17,753)	3	3
4	Revenue Offset to Food	(11,976)	1	4
5	Non Allowable Dues	(218)	20	5
6	Non Allowable Travel & Seminar	(241)	24	6
7	Disallow Non Allowable lobbying	(1,572)	20	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	(41,996)		49

#REF!

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
N/A	N/A	N/A		N/A		N/A

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item							
1	V			\$	N/A		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	Marilyn Resch	President	Administrative	0.00	0	1	2.00	N/A	\$ N/A	N/A	1	
2	David Belt	Vice President	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	2	
3	Ted Perillo *	Secretary	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	3	
4	Marcia Vidoni	Vice President	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	4	
5	Bruce Brown	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	5	
6	Linda Fahy	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	6	
7	Ginny Collins-Knierim	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	7	
8	Peggy Hamilton	Vice President	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	8	
9	Erik Huddlestun	Director	Administrative	0.00	0	1	2.00	N/A	N/A	N/A	9	
10											10	
11	* Ted Perillo is the owner of the Pharmacie Shoppe which provides pharmacy services and supplies to the facility.											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

#REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								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	TOTALS				\$	\$		\$	25

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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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	Regents Bank		X	Line of Credit	None	02/2005	250,000	375,000	Demand	0.0475	13,443						
7																	
8	Various		X	Finance Charges							3,944						
9	TOTAL Facility Related						\$ 250,000	\$ 375,000			\$ 17,387						
B. Non-Facility Related*																	
10											Less : Interest Income offset (257)						
11											Non-Allowable Finance Charges (3,944)						
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,201)						
15	TOTALS (line 9+line14)						\$ 250,000	\$ 375,000			\$ 13,186						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate

1. Real Estate Tax accrual used on 2008 report.		\$	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.)	2008	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	N/A	12
Facility is a not for profit entity and is exempt from real estate taxes.			
Real estate tax is paid on non care assets; however, the tax is adjusted out of the cost report per instructions			
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.

#REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923 Report Period Beginning:

07/01/08 Ending:

06/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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).

None

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>Resident Care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	1
2					2
3	TOTALS	152,472		\$ 24,000	3

#REF!

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	60	1964	1964	\$ 385,838	\$	25	\$	\$	\$ 385,838	4
5		1966	1966	8,491		25			8,491	5
6		1970	1970	3,400		25			3,400	6
7		1972	1972	11,798		25			11,798	7
8	21	1996	1996	828,949	20,724	40	20,724		269,413	8
Improvement Type**										
9	Building improvements		1973	7,123		10			7,123	9
10	Building improvements (less disposition of \$1,076 in '07-'08)		1974	27,871		14-30			28,947	10
11	Building improvements (less disposition of \$1,773 in 2005-06)		1975	5,291		10-30			5,291	11
12	Building improvements		1976	1,607	28	10-30	28		1,606	12
13	Building improvements		1977	1,808		7			1,808	13
14	Building improvements (less disposition of \$4,880 in 2006-07)		1978	1,281		5-15			1,281	14
15	Building improvements		1979	949		10			949	15
16	Building improvements		1980	5,829		7			5,829	16
17	Building improvements		1981	1,376		7			1,376	17
18	Building improvements		1982	11,926		3-30			11,926	18
19	Building improvements		1983	6,263		5			6,263	19
20	Building improvements (less disposition of \$1,974 in 2004-05)		1984	16,740		5-15			16,740	20
21	Building improvements (less disposition of \$480 in 2005-06)		1985	5,320		5-15			5,320	21
22	Building improvements (less disposition of \$28,007 in 2005-06)		1986	17,785		10-20			17,785	22
23	Building improvements (less disposition of \$157 in 2006-07)		1987	27,530		5-15			27,530	23
24	Building improvements		1988	4,282		12-15			4,282	24
25	Building improvements (less disposition of \$610 in '07-'08)		1989	2,259		15			2,869	25
26										26
27	Building improvements (less disposition of \$2,795 in 2002-03)		1991	631		10			631	27
28	Heating/air system		1992	80,277	4,014	20	4,014		72,920	28
29	Building improvements		1992	3,084		10			3,084	29
30	Building improvements		1992	2,168		10			2,168	30
31										31
32	Building improvements		1992	647		10			647	32
33	Building improvements		1992	4,263		15			4,263	33
34	Ceiling/floor		1992	49,923	2,496	20	2,496		40,879	34
35	Sprinkler system		1992	60,121	3,006	20	3,006		50,101	35
36	Storage shelving		1993	4,090		10			4,090	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 #REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/08

Ending:

06/30/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Storage shelving	1993	\$ 1,003	\$	10	\$	\$	\$ 1,003	37
38	Resident security system	1993	3,909	195	20	195		3,206	38
39	Cabinets	1993	42,611	2,311	15-20	2,311		35,737	39
40	Heating/air/tubs	1993	29,226	1,461	20	1,461		22,649	40
41	Fire alarm system	1993	12,350	618	20	618		11,067	41
42	Plumbing and water system	1993	8,684	434	20	434		7,054	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	517	20	517		7,613	44
45	Building improvements	1995	22,859		10-20			22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		22,928	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		9,353	48
49	Sprinklers	1996	9,774	244	40	244		2,928	49
50	Painting	1996	4,052	101	40	101		1,075	50
51	General contractor fees	1996	7,841	196	40	196		2,352	51
52	Electrical	1996	18,390	460	40	460		5,307	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		8,070	53
54	Cubicle curtain tracking	1996	742	37	20	37		488	54
55	Room signs	1996	3,331	167	20	167		2,168	55
56	Emergency lighting Jones wing	1996	142	7	20	7		95	56
57	Bath systems Jones wing	1996	8,610	431	20	431		5,600	57
58	Sprinklers Jones wing	1996	340		10			408	58
59	Security locks Jones wing	1996	1,049	52	20	52		679	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		1,222	61
62	Air filtration Jones wing	1996	2,081	104	20	104		1,352	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750		10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		1,413	65
66	Plumbing	1996	4,640	232	20	232		3,216	66
67	Electrical work (less disposition of \$1,500 in 2005-06)	1996	3,162	233	20	233		2,343	67
68	Flooring	1996	2,400	120	20	120		1,540	68
69	Courtyard	1996	2,766	138	20	138		1,786	69
70	TOTAL (lines 4 thru 69)		\$ 1,919,114	\$ 41,794		\$ 41,794	\$	\$ 1,195,647	70

#REF!

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		\$ 1,919,114	\$ 41,794		\$ 41,794	\$	\$ 1,195,647	1
2	Concrete work entrance	1996	1,470	74	20	74		944	2
3	Building appraisal	1997	2,578	64	40	64		64	3
4	Chapel HVAC	1997	2,324	116	20	116		1,455	4
5	Stained glass window	1997	2,052	103	20	103		1,257	5
6	Steel door	1997	422	21	20	21		257	6
7	Hot water heater-North Wing (less disposition \$3,838 in '06-'07)	1997		79	20	79		79	7
8									8
9	Hand rails	1997	5,252	263	20	263		3,151	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		6,866	11
12	Fire system work	1997	513	26	20	26		304	12
13	Key pad - security system	1997	360	18	20	18		213	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		529	15
16	Hot water heater (less disposition of \$7,318 in 2006-07)	1998		152	20	152		152	16
17	Bed light installation	1998	1,826	91	20	91		1,034	17
18	Hand rails	1998	1,413	71	20	71		795	18
19	Sprinklers	1998	708	35	20	35		398	19
20	Generator bypass switch	1998	1,567	78	20	78		875	20
21									21
22	Lighting - kitchen	1998	985	49	20	49		546	22
23	Paging system	1998	516	26	20	26		282	23
24	Room divider remodeling	1998	391	20	20	20		214	24
25	Bathroom lighting	1998	1,090	55	20	55		590	25
26	South wing remodeling	1998	165	8	20	8		16	26
27	Roof over generator room	1998	568	28	20	28		307	27
28	Bathrooms	1998	7,394	370	20	370		3,975	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		3,290	29
30	Fire Alarm System	1999	1,317	66	20	66		675	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		839	31
32		1999	1,760	88	20	88		895	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,974,070	\$ 44,709		\$ 44,709	\$	\$ 1,225,649	34

#REF!

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		\$ 1,974,070	\$ 44,709		\$ 44,709	\$	\$ 1,225,649	1
2	Generator panel	2000	2,023	202	10	202		1,939	2
3	Gazebo	2000	2,733	273	10	273		2,323	3
4	Anti-scald valves (2)	2001	655	65	10	65		556	4
5	Shower floor replacement	2001	500	25	20	25		213	5
6	Dining room lights	2001	6,013	301	20	301		2,556	6
7									7
8	Toilet stools & seats	2001	1,414	141	10	141		1,105	8
9	Parking lot asphalt reseal	2001	5,032	251	20	251		1,949	9
10	Ceramic wall tile	2001	365	18	20	18		141	10
11	Washer & nurse call	2001	485	48	10	48		367	11
12	Bath fans	2001	150	15	10	15		114	12
13	Extend legs on links	2001	607	61	10	61		461	13
14	Wallpaper front lobby	2001	150	15	10	15		116	14
15	Remodel North & South showers	2002	2,332	116	20	116		845	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912	91	10	91		661	16
17	Water heater	2002	4,165	208	20	208		1,475	17
18									18
19	Compressor - freezer	2002	810	81	10	81		560	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		93	20
21	Carpet	2003	2,887	144	20	144		974	21
22	Bypass switch for generator	2003	2,166	108	20	108		667	22
23	Sign	2003	850	85	10	85		538	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		1,074	25
26	Water Heater	2004	6,548	327	20	327		1,828	26
27	Wireless Monitoring System	2004	4,263	426	10	426		2,344	27
28	Water heater	2004	3,475	174	20	174		941	28
29	Lights, smoke detectors, other	2004	2,562	256	10	256		1,345	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		\$ 2,033,608	\$ 48,381		\$ 48,381	\$	\$ 1,250,834	34

#REF!

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	
1	Totals from Page 12C, Carried Forward		\$ 2,033,608	\$ 48,381		\$ 48,381	\$	\$ 1,250,834	1
2	Security fence (less disposition of \$2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		1,308	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		1,310	4
5	Windows - South Wing	2005	5,499	275	15	275		1,306	5
6	Windows - H Wing	2005	4,132	207	20	207		965	6
7	Handrails	2005	1,375	92	20	92		420	7
8	2 ton compressor	2005	558	37	15	37		224	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		2,456	10
11	Generator	2005	20,000	2,000	10	2,000		7,000	11
12									12
13	Roof	2006	10,657	273	39	273		819	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		209	14
15									15
16	Roof Repair	2008	4,587	167	27.5	167		167	16
17									17
18	Canopy Sprinkler System	2008	9,685	538	15	538		538	18
19	Jones Wing Door Alarms	2008	3,706	144	15	144		144	19
20	Hutton Wing New Doors	2009	5,100	170	15	170		170	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)		\$ 2,124,060	\$ 53,653		\$ 53,653	\$	\$ 1,267,870	34

#REF!

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

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	\$ 306,585	\$ 27,648	\$ 27,648	\$	5-20	\$ 237,353	71
72	Current Year Purchases	14,803	1,790	1,790		10	1,790	72
73	Fully Depreciated Assets	255,180					255,180	73
74								74
75	TOTALS	\$ 576,568	\$ 29,438	\$ 29,438	\$		\$ 494,323	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	Resident Care	1994 Ford Van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77										77
78										78
79										79
80	TOTALS			\$ 41,610	\$	\$	\$		\$ 41,610	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)	\$ 2,766,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,091	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,091	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,803,803	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	See Schedule 13A Attached	292,069	3,197	27,783	87
88					88
89					89
90					90
91	TOTALS	\$ 292,069	\$ 3,197	\$ 27,783	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

#REF!

Heartland Manor Nursing Center
Provider #: 00002923
7/1/08 to 6/30/09

Schedule 13A

XI. Ownership CostsSpecial Services

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

<u>Description & Year Acquired</u>	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Accumulated Depreciation</u>
Aklinski building - 1994	40,045	1,027	14,119
Aklinski concrete work - 1994	3,900	195	2,275
Land - 1994, 1998, 2002, 2005	35,000		
Repp house - 1998	38,500	963	7,341
405 NW 3rd house - 2005	67,629	1,012	4,048
Architect fees for Assisted Living - 2005	2,915		
410 NW 3rd Street - LAND	46,040		
403 NW 3rd Street - LAND	58,040		
TOTALS	<u>292,069</u>	<u>3,197</u>	<u>27,783</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 5,388 Description: \$1,380 Mattresses; \$4,008 Washer / Dryer

(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			<u>N/A</u>		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 Manor Nursing Center # 0002923 Report Period Beginning: 07/01/08 Ending: 06/30/09
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	L10A, C3	hrs	\$	434	\$ 46,798	\$	434	\$ 46,798	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		66	4,283		66	4,283	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,116	52,799		1,116	52,799	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				51,676		51,676	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	L39, C3			83	3,300		83	3,300	12
13	Other (specify): <u>Oxygen</u>	L39, C2					3,935		3,935	13
14	TOTAL			\$	1,699	\$ 107,180	\$ 55,611	1,699	\$ 162,791	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.

#REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/08

Ending:

06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09 (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	\$ 41,459	\$ 41,459	1
2	Cash-Patient Deposits	12,109	12,109	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>18,000</u>)	514,862	514,862	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,935	28,935	6
7	Other Prepaid Expenses	31,822	31,822	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 629,187	\$ 629,187	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,151	20,151	12
13	Land	183,625	24,000	13
14	Buildings, at Historical Cost	2,245,811	2,124,060	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	598,879	618,178	16
17	Accumulated Depreciation (book methods)	(1,762,604)	(1,803,803)	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 (spec <u>Security Deposits</u>)	334	334	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,286,196	\$ 982,920	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,915,383	\$ 1,612,107	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 64,067	\$ 64,067	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,109	12,109	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,536	131,536	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,777	28,777	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other Current Liabilities</u>	86,256	86,256	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 322,745	\$ 322,745	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	375,000	375,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 375,000	\$ 375,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 697,745	\$ 697,745	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,217,638	\$ 914,362	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,915,383	\$ 1,612,107	48

#REF!

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,253,841	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,253,841	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(36,201)	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)	\$ (36,201)	17
B. Transfers (Itemize):			
18			18
19	Rounding	(2)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,217,638	24 *

* This must agree with page 17, line 47.

#REF!

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	\$ 2,662,481	1
2	Discounts and Allowances for all Levels	(138,183)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,524,298	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	151,779	6
7	Oxygen	30,497	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 182,276	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,976	14
15	Telephone, Television and Radio	1,722	15
16	Rental of Facility Space	14,500	16
17	Sale of Drugs	50,630	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,034	19
20	Radiology and X-Ray	562	20
21	Other Medical Services	51,976	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,400	23
D. Non-Operating Revenue			
24	Contributions	6,925	24
25	Interest and Other Investment Income***	257	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,182	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	22,986	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,986	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,870,142	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	662,786	31
32	Health Care	1,290,189	32
33	General Administration	689,304	33
B. Capital Expense			
34	Ownership	112,288	34
C. Ancillary Expense			
35	Special Cost Centers	100,030	35
36	Provider Participation Fee	51,746	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,906,343	40
41	Income before Income Taxes (line 30 minus line 40)**	(36,201)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (36,201)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. #REF!

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

Heartland Manor Nursing Center
Provider #: 00002923
7/1/08 to 6/30/09

Schedule 19A

XXil. Income Statement
Line 28 - Other Revenue

<u>Description & Year Acquired</u>	<u>Cost</u>
Medicare Settlement	1,611
Vending Income	120
Oil Income	1,508
Cleaning Income	17,753
Miscellaneous Other Income	1,994
Total agreeing to Page 19 - Line 28	<u>22,986</u>

See Accountants' Compilation Report

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/08

Ending: 06/30/09

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	1,893	2,048	\$ 49,863	\$ 24.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,476	11,566	229,562	19.85	3
4	Licensed Practical Nurses	10,180	11,406	209,394	18.36	4
5	CNAs & Orderlies	41,649	43,614	459,646	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,928	2,080	26,424	12.70	9
10	Activity Assistants	2,078	2,390	20,681	8.65	10
11	Social Service Workers	786	1,131	16,691	14.76	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	26,263	12.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,017	19,422	166,420	8.57	15
16	Dishwashers					16
17	Maintenance Workers	4,178	4,334	51,592	11.90	17
18	Housekeepers	7,348	8,062	67,244	8.34	18
19	Laundry	6,380	7,327	62,093	8.47	19
20	Administrator	2,063	2,371	53,193	22.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,348	7,997	108,544	13.57	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					31
32	Other Health Care: <u>Care Plan Coordin</u>	3,055	3,595	34,184	9.51	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,233	129,423	\$ 1,581,794 *	\$ 12.22	34

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	96	\$ 4,896	L1, C3	35
36	Medical Director	18	3,375	L9, C3	36
37	Medical Records Consultant	20	2,300	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,015	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,010	L11, C3	44
45	Social Service Consultant	48	3,010	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	\$ 17,606		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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

** See instructions.

###

Heartland Manor Nursing Center
Support Schedules
07/01/08 - 06/30/09
Provider # 00002923

Schedule 21 A

Section C - Professional Fees

TOTAL (agrees to Schedule V, line 19, column : 69,120

Add:

Reclass Personnel Planners 930

TOTAL (agrees to Schedule V, line 19, column : 70,050

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

#REF!

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/08

Ending: 06/30/09

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. Illinois Healthcare Assoc. - \$3,893
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,840 Line L10, C2
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,746
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. \$ 11,976
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larsson, Woodyard & Henson LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

#REF!