

Facility Name & ID Number Heartland of Henry

0049452 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 _____

	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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	6,593	13,460	8,266	28,319	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,593	13,460	8,266	28,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.54%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 4/1/1989

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 66 and days of care provided 6,638

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	224,831	13,961	10,701	249,493	4,952	254,445		254,445		1
2	Food Purchase		156,292		156,292		156,292	(2,347)	153,945		2
3	Housekeeping	83,760	16,064	323	100,147		100,147		100,147		3
4	Laundry	47,345	9,733		57,078		57,078		57,078		4
5	Heat and Other Utilities			170,479	170,479	1,378	171,857		171,857		5
6	Maintenance	42,972	11,809	44,100	98,881		98,881		98,881		6
7	Other (specify):* Medical Waste			445	445		445		445		7
8	TOTAL General Services	398,908	207,859	226,048	832,815	6,330	839,145	(2,347)	836,798		8
	B. Health Care and Programs										
9	Medical Director			18,411	18,411		18,411		18,411		9
10	Nursing and Medical Records	1,603,910	125,210	48,041	1,777,161	1,818	1,778,979		1,778,979		10
10a	Therapy	585,554	6,003	23,081	614,638		614,638		614,638		10a
11	Activities	66,946	3,195	3,143	73,284		73,284	(50)	73,234		11
12	Social Services	66,344	748		67,092		67,092		67,092		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,322,754	135,156	92,676	2,550,586	1,818	2,552,404	(50)	2,552,354		16
	C. General Administration										
17	Administrative	88,131		237,299	325,430	(62,332)	263,098		263,098		17
18	Directors Fees										18
19	Professional Services			4,459	4,459		4,459	(780)	3,679		19
20	Dues, Fees, Subscriptions & Promotions			55,146	55,146		55,146	(43,034)	12,112		20
21	Clerical & General Office Expenses	138,716	43,164	(22,912)	158,968		158,968	43,571	202,539		21
22	Employee Benefits & Payroll Taxes			521,227	521,227	41,111	562,338		562,338		22
23	Inservice Training & Education			2,553	2,553		2,553		2,553		23
24	Travel and Seminar			12,529	12,529		12,529		12,529		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			196,977	196,977		196,977		196,977		26
27	Other (specify):*										27
28	TOTAL General Administration	226,847	43,164	1,007,278	1,277,289	(21,221)	1,256,068	(243)	1,255,825		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,948,509	386,179	1,326,002	4,660,690	(13,073)	4,647,617	(2,640)	4,644,977		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 of Henry

#0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			242,444	242,444	10,992	253,436		253,436			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(961)	(961)	2,081	1,120		1,120			32
33	Real Estate Taxes			117,440	117,440		117,440		117,440			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			73,382	73,382		73,382		73,382			35
36	Other (specify):*											36
37	TOTAL Ownership			432,305	432,305	13,073	445,378		445,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,342		196,342		196,342		196,342			39
40	Barber and Beauty Shops			14,254	14,254		14,254		14,254			40
41	Coffee and Gift Shops	20,474			20,474		20,474		20,474			41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):* IV X-Ray & Lab		50,844	30,282	81,126		81,126		81,126			43
44	TOTAL Special Cost Centers	20,474	247,186	96,001	363,661		363,661		363,661			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,968,983	633,365	1,854,308	5,456,656		5,456,656	(2,640)	5,454,016			45

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

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	(2,347)	2		4
5	Telephone, TV & Radio in Resident Rooms	(28)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		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	(368)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(780)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	47,382	21		24
25	Fund Raising, Advertising and Promotional	(43,034)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,659)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,640)		\$	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)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,640)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Heartland of Henry

ID# 0049452
 Report Period Beginning: 01/01/09
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,259)	21	1
2	Misc. Income	(1,350)	21	2
3	Activity Income	(50)	11	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,659)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Henry# 0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,347)	0	0	0	0	0	0	0	0	0	0	(2,347)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,347)	0	(2,347)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(50)	0	(50)	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	(780)	0	0	0	0	0	0	0	0	0	0	(780)	19
20	Fees, Subscriptions & Promotions	(43,034)	0	0	0	0	0	0	0	0	0	0	(43,034)	20
21	Clerical & General Office Expenses	43,571	0	0	0	0	0	0	0	0	0	0	43,571	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	(243)	0	(243)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,640)	0	(2,640)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Henry# 0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(2,640)	0	0	0	0	0	0	0	0	0	0	(2,640)	45

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
HCR Manor Care, Inc.	100	Health Care & Retirement Corporation 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	\$ 237,298	HCR Manor Care, Inc.	100.00%	\$ 237,298	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	20,466	Heartland Rehab Services, LLC	100.00%	20,466		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 257,764			\$ 257,764	\$ *	14

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

Facility Name & ID Number

Heartland of Henry

#

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	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 of Henry

0049452

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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 to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	\$ 2,826,629	\$ 1,585,087	5,006,358	\$ 4,952	1
2	1	Dietary - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			5,006,358	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rehab			5,006,358	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.			5,006,358	0	4
5	5	Utilities - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			5,006,358	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	911,333		5,006,358	1,378	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	5,006,358	1,108	7
8	10	Nursing - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			5,006,358	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	469,810		5,006,358	710	9
10	17	Gen & Admin - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981		5,006,358	62,224	10
11	17	Gen & Admin - Direct to Central	Accumulated Cost	691,284,298	95 NFs	1,045,204		5,006,358	7,569	11
12	17	Gen & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	69,554,530	79,745,671	5,006,358	105,173	12
13	22	Emp Benefits- Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311		5,006,358	10,930	13
14	22	Emp Benefits - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	2,434,366		5,006,358	17,630	14
15	22	Emp Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	8,300,418		5,006,358	12,551	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714		5,006,358	180	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	43,612		5,006,358	316	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	6,941,685		5,006,358	10,496	18
19										19
20	32	Interest				21,122,019			2,081	20
21		Non-Nursing Home Allocations				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 237,298	25

Facility Name & ID Number

Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv. Sub Debentures		X	Facility				\$ 81,733	\$ 81,733		2,5800	\$ 2,081	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income Other											(961)	8							
9	TOTAL Facility Related						\$ 81,733	\$ 81,733				\$ 1,120	9							
B. Non-Facility Related*																				
10													10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$				\$	14							
15	TOTALS (line 9+line14)						\$ 81,733	\$ 81,733				\$ 1,120	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

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

1. Real Estate Tax accrual used on 2008 report.		\$	104,469	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.)		\$	110,955	2
3. Under or (over) accrual (line 2 minus line 1).		\$	6,486	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	110,954	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.		\$	117,440	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	97,268	8	
	2005	92,135	9	
	2006	106,392	10	
	2007	104,469	11	
	2008	110,954	12	
				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.

Facility Name & ID Number Heartland of Henry

0049452 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 174,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 174,000	3

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1988	1988	\$ 1,748,953	\$ 53,363		\$ 53,363	\$	\$ 1,002,957	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					102,626		102,626		1,089,048	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	7/1/03 Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,948,456	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	70

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

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,948,456	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	1
2	PAINTING FOR RESIDENTS ROOMS	2000	3,000						2
3	DOOR HARDWARE	2000	906						3
4	PAINTING	2000	730						4
5	PAINTING	2000	3,000						5
6	DRYWALL	2000	(3,000)						6
7	SMOKE DAMPERS	2000	7,280						7
8	ADDL'T COST SMOKE DAMPERS	2000	658						8
9	TOTAL DOORS	2000	73						9
10	WALLCOVERING	2000	610						10
11	WALLCOVERING	2000	170						11
12	WALLCOVERING	2000	709						12
13	WALLCOVERING	2000	519						13
14		2000	299						14
15	CEILING								15
16	CUSTOM WORKSTATION	2001	1,225						16
17	PAINT & WALLCOVERING	2001	2,067						17
18	WALLCOVERING - LOUNGE RENOVATION	2001	1,760						18
19	WINDOWS	2001	557						19
20	HOT WATER HEATERS	2001	855						20
21	DRAPES	2001	7,900						21
22	CARPET	2001	2,980						22
23	ADDTL COSTS FOR CARPET	2001	29,586						23
24	CARPET	2001	2,260						24
25	WALLCOVERING	2001	500						25
26	WALLCOVERING	2001	516						26
27	CARPENTRY - LOUNGE RENOVATION	2001	90						27
28	DRAPES, SHADES, BLINDS - LOUNGE RENOVATION	2001	6,002						28
29	CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION	2001	1,109						29
30	PAINTING, WALLCOVERING - LOUNGE RENOVATION	2001	10,360						30
31	PLUMBING - LOUNGE RENOVATION	2001	9,691						31
32	CONCRETE	2001	4,425						32
33		2001	2,248						33
34	TOTAL (lines 1 thru 33)		\$ 3,047,541	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	34

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

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 3,047,541	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,268,248	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	34

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

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 12C, Carried Forward		\$ 3,268,248	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,528,481	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	34

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

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 12D, Carried Forward		\$ 3,528,481	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						19
20	2 concrete sidewalks	2008	2,600						20
21	CARPENTRY	2008	500						21
22	0907 EMERGENCY LIGHTING	2008	6,357						22
23	0907 EMERGENCY LIGHTING	2008	38,409						23
24	0907 EMERGENCY LIGHTING	2008	6,454						24
25	0907 EMERGENCY LIGHTING	2008	4,450						25
26	AC CONDENSING UNIT	2008	4,287						26
27	ELECTRICAL FOR TVS	2008	10,260						27
28	SERVICE DOOR ENTRANCE1	2008	5,365						28
29	FIRE RATED SHUTTER	2008	4,806						29
30	DOOR FOR ENTRANCE	2008	5,365						30
31	entrance doors	2008	1,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,711,720	\$ 155,989		\$ 155,989	\$	\$ 2,092,005	34

**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	\$ 1,569,515	\$ 86,455	\$ 86,455	\$		\$ 1,277,334	71
72	Current Year Purchases	25,965						72
73	Fully Depreciated Assets							73
74	H/O Allocation			10,992	10,992			74
75	TOTALS	\$ 1,595,480	\$ 86,455	\$ 97,447	\$ 10,992		\$ 1,277,334	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,481,200	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 242,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,436	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,992	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,369,339	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	Various	\$ 9,769	92
93			93
94			94
95		\$ 9,769	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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? _____

16. Rental Amount for movable equipment: \$ 43,218 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. 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	<u>Patient Transportation</u>	<u>2006 Ford Van</u>	\$ _____	\$ <u>30,164</u>	17
18				<u>above figures includes</u>	18
19				<u>gas & maintenance too</u>	19
20					20
21	TOTAL		\$ _____	\$ <u>30,164</u>	21

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 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	1265	hrs	\$ 47,865		\$	1,389	1,265	\$ 49,254	1
2	Licensed Speech and Language Development Therapist	10a	1416	hrs	53,551	6	318	57	1,422	53,926	2
3	Licensed Recreational Therapist		4206	hrs	159,114	4	192	4,557	4,210	163,863	3
4	Licensed Physical Therapist	10a		hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts			13,988	196,342		210,330	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						50,844		50,844	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					30,282			30,282	13
14	TOTAL				\$ 260,530	10	\$ 44,780	\$ 253,189	6,897	\$ 558,499	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 of Henry# 0049452Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 6,439	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(134,757)</u>)	626,524		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 632,963	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	3,711,720		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,595,480		16
17	Accumulated Depreciation (book methods)	(3,369,338)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	9,769		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,121,631	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,754,594	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 90,383	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,454		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,954		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	26,411		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 429,202	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	46,286		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,286	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 475,488	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,279,106	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,754,594	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,558,294	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,558,294	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,659,190	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,659,190	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,938,378)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,938,378)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,279,106	24 *

* This must agree with page 17, line 47.

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	\$ 6,735,840	1
2	Discounts and Allowances for all Levels	(1,517,804)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,218,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,581,276	6
7	Oxygen	3,085	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,584,361	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,508	12
13	Barber and Beauty Care	20,215	13
14	Non-Patient Meals	2,347	14
15	Telephone, Television and Radio	28	15
16	Rental of Facility Space	1,350	16
17	Sale of Drugs	220,167	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,914	19
20	Radiology and X-Ray	4,381	20
21	Other Medical Services	28,856	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 308,766	23
D. Non-Operating Revenue			
24	Contributions	3,333	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,333	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc. Income & Purchase Discounts</u>	1,350	28
28a	<u>Late Charges</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,350	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,115,846	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	832,815	31
32	Health Care	2,550,586	32
33	General Administration	1,277,289	33
B. Capital Expense			
34	Ownership	432,305	34
C. Ancillary Expense			
35	Special Cost Centers	312,196	35
36	Provider Participation Fee	51,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,456,656	40
41	Income before Income Taxes (line 30 minus line 40)**	1,659,190	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,659,190	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 of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,999	2,210	\$ 74,823	\$ 33.86	1
2	Assistant Director of Nursing	3,962	4,381	104,379	23.83	2
3	Registered Nurses	11,297	12,492	282,193	22.59	3
4	Licensed Practical Nurses	21,066	23,293	433,880	18.63	4
5	CNAs & Orderlies	56,778	62,869	681,657	10.84	5
6	CNA Trainees					6
7	Licensed Therapist	6,887	7,559	285,962	37.83	7
8	Rehab/Therapy Aides	11,219	12,314	299,592	24.33	8
9	Activity Director	5,484	6,080	66,946	11.01	9
10	Activity Assistants					10
11	Social Service Workers	3,902	4,327	66,344	15.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,542	22,779	224,831	9.87	15
16	Dishwashers					16
17	Maintenance Workers	2,338	2,590	42,972	16.59	17
18	Housekeepers	7,889	8,750	83,760	9.57	18
19	Laundry	4,736	5,250	47,345	9.02	19
20	Administrator	2,080	2,080	88,131	42.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,448	9,731	138,716	14.26	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	1,485	1,646	26,978	16.39	31
32	Other Health Care(specify)	2,055	2,277	20,474	8.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,167	190,628	\$ 2,968,983 *	\$ 15.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	18,411	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,988	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Medical Services		193	10, 3	47
48					48
49	TOTAL (lines 35 - 48)	\$	32,592		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland of Henry

0049452

Report Period Beginning:

01/01/09

Ending:

12/31/09

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. IHCA \$3474
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$ 3897 If YES, have these costs been properly adjusted out of the cost report? Yes
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,434 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,347
- (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: _____
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.