



Facility Name & ID Number Heartland Health Care Center - Paxton

# 6011571 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	96	Skilled (SNF)	96	35,040	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	96	TOTALS	96	35,040	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	3,496	18,697	9,968	32,161	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,496	18,697	9,968	32,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.78%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/03/1988

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/1989 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 96 and days of care provided 7,075

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  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 Health Care Center - Paxton # 6011571 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
	<b>A. General Services</b>										
1	Dietary	260,599	29,033	52,571	342,203	6,456	348,659		348,659		1
2	Food Purchase		213,194		213,194		213,194	(10,146)	203,048		2
3	Housekeeping	110,905	17,271	861	129,037		129,037		129,037		3
4	Laundry	35,990	7,618		43,608		43,608		43,608		4
5	Heat and Other Utilities			179,062	179,062	1,797	180,859		180,859		5
6	Maintenance	78,465	13,198	58,718	150,381		150,381		150,381		6
7	Other (specify):* <b>Medical Waste</b>			1,219	1,219		1,219		1,219		7
8	<b>TOTAL General Services</b>	485,959	280,314	292,431	1,058,704	8,253	1,066,957	(10,146)	1,056,811		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,798	26,798		26,798		26,798		9
10	Nursing and Medical Records	2,102,048	138,730	72,114	2,312,892	2,371	2,315,263		2,315,263		10
10a	Therapy	750,245	17,988	104,957	873,190		873,190		873,190		10a
11	Activities	95,135	6,905	3,097	105,137		105,137		105,137		11
12	Social Services	123,273	383	3,097	126,753		126,753		126,753		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,070,701	164,006	210,063	3,444,770	2,371	3,447,141		3,447,141		16
	<b>C. General Administration</b>										
17	Administrative	145,751		322,430	468,181	(94,308)	373,873		373,873		17
18	Directors Fees										18
19	Professional Services			5,289	5,289		5,289	(1,875)	3,414		19
20	Dues, Fees, Subscriptions & Promotions			67,309	67,309		67,309	(29,104)	38,205		20
21	Clerical & General Office Expenses	197,512	46,606	(64,615)	179,503		179,503	141,048	320,551		21
22	Employee Benefits & Payroll Taxes			742,591	742,591	53,601	796,192		796,192		22
23	Inservice Training & Education			12,647	12,647		12,647		12,647		23
24	Travel and Seminar			34,624	34,624		34,624		34,624		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			206,514	206,514		206,514		206,514		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	343,263	46,606	1,326,789	1,716,658	(40,707)	1,675,951	110,069	1,786,020		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,899,923	490,926	1,829,283	6,220,132	(30,083)	6,190,049	99,923	6,289,972		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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			355,917	355,917	14,332	370,249		370,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,598)	(1,598)	15,751	14,153		14,153			32
33	Real Estate Taxes			75,880	75,880		75,880		75,880			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,345	57,345		57,345		57,345			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			487,544	487,544	30,083	517,627		517,627			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			357	357		357		357			38
39	Ancillary Service Centers		204,588		204,588		204,588		204,588			39
40	Barber and Beauty Shops		1,320	22,794	24,114		24,114		24,114			40
41	Coffee and Gift Shops	27,120			27,120		27,120		27,120			41
42	Provider Participation Fee			53,295	53,295		53,295		53,295			42
43	Other (specify):* <b>IV   X-Ray &amp; Lab</b>		14,745	59,378	74,123		74,123		74,123			43
44	<b>TOTAL Special Cost Centers</b>	27,120	220,653	135,824	383,597		383,597		383,597			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,927,043	711,579	2,452,651	7,091,273		7,091,273	99,923	7,191,196			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,146)	2		4
5	Telephone, TV & Radio in Resident Rooms		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	1	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(614)	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		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,875)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	143,599	21		24
25	Fund Raising, Advertising and Promotional	(29,104)	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	(1,282)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 99,923		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 99,923		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Heartland Health Care Center - Paxton

ID# 6011571

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$	(1,130)	21 1
2	Misc. Income		(152)	21 2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(1,282)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center - Paxton# 6011571

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	(10,146)	0	0	0	0	0	0	0	0	0	0	(10,146)	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	<b>TOTAL General Services</b>	<b>(10,146)</b>	<b>0</b>	<b>(10,146)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,875)	0	0	0	0	0	0	0	0	0	0	(1,875)	19
20	Fees, Subscriptions & Promotions	(29,104)	0	0	0	0	0	0	0	0	0	0	(29,104)	20
21	Clerical & General Office Expenses	141,048	0	0	0	0	0	0	0	0	0	0	141,048	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>110,069</b>	<b>0</b>	<b>110,069</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>99,923</b>	<b>0</b>	<b>99,923</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center - Paxton# 6011571

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)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	99,923	0	0	0	0	0	0	0	0	0	0	99,923	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	\$ 322,430	HCR Manor Care, Inc.	100.00%	\$ 322,430	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	30,461	Heartland Rehab Services, LLC	100.00%	30,461		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 352,891			\$ 352,891	\$ *	14

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

Facility Name & ID Number Heartland Health Care Center - Paxton # 6011571 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 Health Care Center - Paxton

# 6011571

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	\$ 2,826,629	\$ 1,585,087	6,527,324	\$ 6,456	1
2	1	Dietary - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			6,527,324	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rehab			6,527,324	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.			6,527,324	0	4
5	5	Utilities - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			6,527,324	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	911,333		6,527,324	1,797	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	6,527,324	1,445	7
8	10	Nursing - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			6,527,324	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	469,810		6,527,324	926	9
10	17	Gen & Admin - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981		6,527,324	81,128	10
11	17	Gen & Admin - Direct to Central	Accumulated Cost	691,284,298	95 NFs	1,045,204		6,527,324	9,869	11
12	17	Gen & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	69,554,530	79,745,671	6,527,324	137,125	12
13	22	Emp Benefits- Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311		6,527,324	14,251	13
14	22	Emp Benefits - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	2,434,366		6,527,324	22,986	14
15	22	Emp Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	8,300,418		6,527,324	16,364	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714		6,527,324	235	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	43,612		6,527,324	412	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	6,941,685		6,527,324	13,685	18
19								6,527,324		19
20	32	Interest				21,122,019			15,751	20
21		Non-Nursing Home Allocations				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 322,430	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	2	3	4	5	6	7	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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Conv. Sub Debentures	X	Facility	N/A		\$ 618,583	\$ 618,583		2.5800	\$ 15,751	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8	Interest Income Other									(1,598)	8								
9	<b>TOTAL Facility Related</b>					\$ 618,583	\$ 618,583			\$ 14,153	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 618,583	\$ 618,583			\$ 14,153	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.		\$	<b>74,179</b>	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.)		\$	<b>75,030</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>851</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>75,029</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>75,880</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>64,120</b>	8	
	2005	<b>73,040</b>	9	
	2006	<b>73,909</b>	10	
	2007	<b>74,179</b>	11	
	2008	<b>75,029</b>	12	
				<b>FOR BHF USE ONLY</b>
	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.**



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,919 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>\$ 75,186</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 75,186</b>	<b>3</b>

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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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96	1988	1988	\$ 1,323,187	\$ 146,550		\$ 146,550	\$	\$ 1,817,315	4
5	Audit Adj (#1) - Overhead & Int		1998	1,129,268						5
6	& Audit Adj (#2) - Various		2001	407,054						6
7			2004	673,649						7
8			2008	649,952						8
<b>Improvement Type**</b>										
9	CURRENT YEAR DEPRECIATION				121,068		121,068		1,022,965	9
10	Land/Bldg. Improvement (See attached schedule		1988	279,229						10
11	Additional Attic Insulation		1989	3,500						11
12	Fire Alarm System		1990	294						12
13	Audit Adj (#3) - Fire Alarm System		1990	(294)						13
14	Land/Bldg. Improvement (See attached schedule		1990	8,348						14
15	Land/Bldg. Improvement (See attached schedule		1991	6,404						15
16	Land/Bldg. Improvement (See attached schedule		1992	24,904						16
17	Land/Bldg. Improvement (See attached schedule		1993	12,778						17
18	Land/Bldg. Improvement (See attached schedule		1994	1,010						18
19	Land/Bldg. Improvement (See attached schedule		1995	14,522						19
20	BATHTUB		1996	356						20
21	(7) DOORS		1996	3,896						21
22	WALLCOVERING		1996	1,133						22
23	CARPET & WALLCOVERING		1996	2,199						23
24	CEILING		1997	2,101						24
25	WALLCOVERING		1997	8,139						25
26	WALLCOVERING		1997	22						26
27	CREDIT ON BLD IMP-CNCLD RETAIN		1997	(434)						27
28	WALLCOVERING		1997	13,695						28
29	CARPET		1997	1,081						29
30	WALLCOVERING		1997	1,571						30
31	ENGINEERING AND ARCHITECTURAL FEES		1997	75,055						31
32	Audit Adj (#4) - Various		1997	(22,168)						32
33	(14) PKG AMANA A/C UNITS		1997	9,051						33
34	PAINTING		1997	10,933						34
35	PAINTING & WALLCOVERING		1997	7,933						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

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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	
37	NURSE CALL SYSTEM	1997	\$ 2,561	\$		\$	\$	\$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	293						38
39	VINYL WALL COVERING FROM INVENTORY	1997	187						39
40	VINYL WALL COVERING FROM INVENTORY	1997	814						40
41	CUBICLE CURTAIN TRACK	1997	1,416						41
42	NURSE CALL SYSTEM UPGRADE	1997	2,305						42
43	WALLCOVERING	1997	157						43
44	CROWN MOLDING & CHAIR RAIL	1997	820						44
45	GARAGE WOOD	1997	12,983						45
46	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						46
47	WALLCOVERING	1998	191						47
48	COVE BASE	1998	1,529						48
49	WALLCOVERING	1998	75						49
50	DOOR ALARMS	1998	3,598						50
51	WALLCOVERING	1998	249						51
52	SECURE CARE LOCKS	1998	11,971						52
53	ADDL'T NURSE CALL SYSTEM	1998	1,901						53
54	WALLPAPER FROM CONSTRUCTION	1998	196						54
55	GATE	1998	390						55
56	A/C UNIT	1998	1,925						56
57	HVAC FOR ADDITION	1998	47,008						57
58	AUDIT ADJ (#5) - VARIOUS	1998	(6,158)						58
59	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						59
60	REMOVE OVERHEAD PAGING	1998	338						60
61	WALLCOVERING	1998	7,678						61
62	CABINETRY & COUTNERTOPS	1998	8,240						62
63	CARPENTRY	1998	24,126						63
64	ELECTRICAL WORK	1998	444						64
65	ELECTRICAL WORK	1998	32,894						65
66	LIGHT FIXTURES	1998	1,253						66
67	PLUMBING WORK	1998	711						67
68	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,832,202	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	70

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,832,202	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	1
2	SPRINKLER SYSTEM	1998	45,812						2
3	FIRE ALARM SYSTEM	1998	3,370						3
4	FENCE	1998	6,507						4
5	PAVING	1998	38,079						5
6	CONSTRUCTION AND DESIGN OVERHEAD COST	1999	114,792						6
7	AUDIT ADJ (#6) - OVERHEAD COST	1999	(114,792)						7
8	DIRECT VENT UNIT HEATER	1999	1,556						8
9	SECURE CARE LOCKING SYSTEM	1999	958						9
10	SEAL & STRIPE PARKING LOT	1999	3,136						10
11	EXTERIOR LIGHTING	1999	20,250						11
12	SINK & FAUCET	2000	596						12
13	NURSES STATION	2000	11,790						13
14	COUNTERTOP	2000	1,200						14
15	VCT	2000	1,140						15
16	WATER HEATER	2000	3,780						16
17	NURSES STATION	2000	475						17
18	PAINTING	2000	11,005						18
19	CUSTOM CABINETS	2000	7,091						19
20	INSTALL CARPET	2001	593						20
21	GAZEBO	2001	4,319						21
22	CARPENTRY-ARCADIA RENOV	2001	16,430						22
23	CARPENTRY-ARCADIA RENOV	2001	13,084						23
24	AUDIT ADJ (#7) - CARPENTRY	2001	(1,469)						24
25	LANDSCAPING-ARCADIA RENOV	2002	21,295						25
26	AUDIT ADJ (#2) - TRANSFER TO BUILDING	2002	(21,295)						26
27	PAINTING	2002	7,175						27
28	PAINTING	2002	825						28
29	DRAPES	2002	130						29
30	FLOORING,VINYL WALL COVERING	2002	8,405						30
31	OUTDOOR LIGHTING	2002	1,560						31
32	DOORS	2002	5,900						32
33	HALLWAY PAINT AND BORDER	2002	1,150						33
34	TOTAL (lines 1 thru 33)		\$ 5,047,049	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,047,049	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	1
2	MDS OFFICE-VINYL WALL COVERING	2003	419						2
3	AUDIT ADJ (#9) - VWC	2003	(25)						3
4	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						4
5	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						5
6	MDS OFFICE-ELECTRIC WORK	2003	1,338						6
7	MDS OFFICE-BORDER	2003	66						7
8	AUDIT ADJ (#10) - BORDER	2003	(4)						8
9	CARPET	2003	1,051						9
10	SNF ADDITION-ARCHITECT COSTS	2003	4,612						10
11	OUTLETS IN DINING ROOM	2003	1,280						11
12	TESTING GEOTECHNICAL	2003	3,519						12
13	ENGINEERING, ARCHITECTURAL FEES	2003	156,819						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(63,267)						14
15	RESILIENT FLOORING	2004	17,087						15
16	7/1/06 CAPITAL RATE ADJUST #1	2004	(137)						16
17	SECURITY DOOR	2004	5,354						17
18	WATER,SEWER,UTILITIES FOR ADDITION	2004	44,792						18
19	7/1/06 CAPITAL RATE ADJUST #2	2004	(44,792)						19
20	VINYL WALL COVERING, FLOORING	2004	12,441						20
21	VINYL WALL COVERING, FLOORING (ADJUSTMENT)	2004	(75)						21
22	MILLWORK	2004	2,815						22
23	NEW ROOF	2004	88,184						23
24	SECURITY DOOR	2005	4,932						24
25	CONCRETE WALK & PAD	2006	558						25
26	5 PTAC UNITS	2006	4,136						26
27	CUSTOM WORKSTATIONS	2006	1,806						27
28	DINING.LOBBY.OFFICE-GENL O/H	2007	6,606						28
29	DINING-CARPENTRY	2007	38,528						29
30	ADMISSIONS-CARPENTRY	2007	10,290						30
31	DINING-WALLCOVERING	2007	3,595						31
32	LOBBY-WALLCOVERING	2007	2,288						32
33	ADMINISTRATOR-WALLCOVERING	2007	855						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,353,169	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	34

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 5,353,169	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	1
2	ADMISSIONS-WALLCOVERING	2007	823						2
3	DINING,LOBBY,OFFICE-INTEREST	2007	486						3
4	CEILING	2007	14,580						4
5	CONF RM BIRD LOUNGE	2006	2,228						5
6	PAXTON_PT - GEN'L CONTRACTOR	2008	980						6
7	PAXTON_PT - LANDSCAPING	2008	11,376						7
8	PAXTON_PT - CONCRETE TESTING	2008	1,478						8
9	PAXTON_PT -SOIL TESTING	2008	2,175						9
10	PAXTON_PT - ARCH & ENGINEER COST	2008	63,523						10
11	PAXTON_PT - GENERAL OVERHEAD CAPITAL	2008	236,698						11
12	PAXTON_PT - PLAN REVIEWS	2008	6,000						12
13	PAXTON_PT - INTEREST ON CONSTRUCTION	2008	37,527						13
14	PAXTON_PT - ELECTRICAL	2008	110						14
15	PAXTON_PT - CARPETING & PADS	2008	1,770						15
16	PAXTON_PT - WALL COVERING	2008	394						16
17									17
18	50587 PAX ADD-Gen contractor	2009	535,865						18
19	000000050576 Ren-Gen ovhd capit	2009	33,063						19
20	000000050576 Renovation-interest on const	2009	1,169						20
21	000000050579 Renovation -Carpentry	2009	91,141						21
22	000000050580 Ren-lobby finishes	2009	3,520						22
23	000000050580 Ren-carpeting & pads	2009	12,110						23
24	000000050580 Ren-wallcovering	2009	14,890						24
25	50582 PAX ADD-Architect & Eng Cost	2009	85,342						25
26	50584 PAX ADD-General Overhead Capital	2009	10,719						26
27	50588 PAX ADD-interest on construction	2009	4,129						27
28	50589 PAX ADD-millwork	2009	4,815						28
29	50590 PAX ADD-wall cov, cubicle track & corn guards	2009	9,608						29
30	50583 PAX ADD-Soil & concrete testing	2009	3,936						30
31	50591 PAX ADD-Gen Contractor-sitework	2009	54,829						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,598,454	\$ 267,618		\$ 267,618	\$	\$ 2,840,280	34

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

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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	\$ 1,580,907	\$ 88,299	\$ 88,299	\$		\$ 1,287,396	71
72	Current Year Purchases	147,016						72
73	Fully Depreciated Assets							73
74	H/O Allocation			14,332	14,332			74
75	TOTALS	\$ 1,727,923	\$ 88,299	\$ 102,631	\$ 14,332		\$ 1,287,396	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)	\$ 8,401,563	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 355,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 370,249	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,332	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,127,676	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	\$ 5,132	92
93			93
94			94
95		\$ 5,132	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: \$ 39,066 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

YES  NO

(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>2009 Dodge Caravan</u>	\$ <u>#####</u>	\$ <u>18,279</u>	17
18				<u>above figures includes</u>	18
19				<u>gas &amp; maintenance too</u>	19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>18,279</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	2242 hrs	\$ 83,274		\$	425	2,242	\$ 83,699	1
2	Licensed Speech and Language Development Therapist	10a	1522 hrs	56,548	12	667	142	1,534	57,357	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7216 hrs	268,074	1,211	68,282	17,421	8,427	353,777	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			5,484	204,588		210,072	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					14,745		14,745	12
13	Other (specify): <u>X-Ray &amp; Lab</u>	43, 3				59,378			59,378	13
14	<b>TOTAL</b>			\$ 407,896	1,223	\$ 133,811	\$ 237,321	12,203	\$ 779,028	14

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

Facility Name & ID Number **Heartland Health Care Center - Paxton**

# **6011571**

Report Period Beginning: **01/01/09**

Ending: **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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 9,685	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (339,948) )	1,011,755		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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,021,440	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	6,598,453		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,727,923		16
17	Accumulated Depreciation (book methods)	(4,127,676)		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): <b>CIP</b>	5,132		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,279,018	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,300,458	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 120,346	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,042		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,030		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Accrued Payable</b>	66,040		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 522,458	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	67,220		42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 67,220	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 589,678	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,710,780	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,300,458	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,255,080</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,255,080</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,559,408</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,559,408</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>(103,708)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(103,708)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,710,780</b>	<b>24</b> *

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

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

# 6011571

Report Period Beginning: 01/01/09

Ending: 12/31/09

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		2	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,133,418	1
2	Discounts and Allowances for all Levels	(1,945,017)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,188,401	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,076,009	6
7	Oxygen	17,358	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,093,367	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,792	12
13	Barber and Beauty Care	29,435	13
14	Non-Patient Meals	10,146	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	220,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,570	19
20	Radiology and X-Ray	44,873	20
21	Other Medical Services	30,311	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 368,653	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	145	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 145	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc. Income &amp; Purchase Discounts</b>	115	28
28a	<b>Late Charges</b>		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 115	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,650,681	30

1		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,058,704	31
32	Health Care	3,444,770	32
33	General Administration	1,716,658	33
<b>B. Capital Expense</b>			
34	Ownership	487,544	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	330,302	35
36	Provider Participation Fee	53,295	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,091,273	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,559,408	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,559,408	43

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

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

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

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

Facility Name & ID Number Heartland Health Care Center - Paxton

# 6011571

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	2,158	2,363	\$ 84,785	\$ 35.88	1
2	Assistant Director of Nursing	5,051	5,530	162,877	29.45	2
3	Registered Nurses	8,897	9,741	246,969	25.35	3
4	Licensed Practical Nurses	29,097	31,855	676,937	21.25	4
5	CNAs & Orderlies	70,272	77,168	908,083	11.77	5
6	CNA Trainees					6
7	Licensed Therapist	10,979	12,160	451,761	37.15	7
8	Rehab/Therapy Aides	10,162	11,255	298,484	26.52	8
9	Activity Director	6,707	7,378	95,135	12.89	9
10	Activity Assistants					10
11	Social Service Workers	6,772	7,449	123,273	16.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,412	23,542	260,599	11.07	15
16	Dishwashers					16
17	Maintenance Workers	4,095	4,502	78,465	17.43	17
18	Housekeepers	9,146	10,062	110,905	11.02	18
19	Laundry	3,613	3,973	35,990	9.06	19
20	Administrator	2,080	2,080	109,303	52.55	20
21	Assistant Administrator	1,491	1,491	36,448	24.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,808	12,599	197,512	15.68	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	1,555	1,709	22,397	13.11	31
32	Other Health Care(specify)	2,017	2,218	27,120	12.23	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,312	227,075	\$ 3,927,043 *	\$ 17.29	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 26,798	9, 3	36
37	Medical Records Consultant	Monthly 350	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 5,484	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	Monthly 12,664	10, 3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 45,296		49

C. CONTRACT NURSES

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





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

# 6011571

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 \$3586
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$3995 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. \$ 49,169 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. \$ 53,295  
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. \$ 10,146
- (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.