

Facility Name & ID Number Heartland of Champaign

0049395 Report Period Beginning: 06/01/09 Ending: 05/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>102</u>	Skilled (SNF)	<u>102</u>	<u>37,230</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,230</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>3,753</u>	<u>13,947</u>	<u>14,288</u>	<u>31,988</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,753</u>	<u>13,947</u>	<u>14,288</u>	<u>31,988</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.92%

D. How many bed-hold days during this year were paid by the Department? 2 (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)
None

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 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 102 and days of care provided 9,695

Medicare Intermediary Highmark Medicare 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: 5/31

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	253,550	22,535	2,360	278,445	7,841	286,286		286,286		1
2	Food Purchase		250,465		250,465		250,465	(10,664)	239,801		2
3	Housekeeping	117,223	15,143	2,404	134,770		134,770		134,770		3
4	Laundry	55,036	12,486	13,741	81,263		81,263		81,263		4
5	Heat and Other Utilities			151,010	151,010	2,182	153,192		153,192		5
6	Maintenance	85,839	22,290	100,871	209,000		209,000		209,000		6
7	Other (specify):* Med Waste			749	749		749		749		7
8	TOTAL General Services	511,648	322,919	271,135	1,105,702	10,023	1,115,725	(10,664)	1,105,061		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,332,170	213,919	212,801	2,758,890	2,880	2,761,770		2,761,770		10
10a	Therapy	877,335	14,317	51,944	943,596		943,596		943,596		10a
11	Activities	81,862	11,558	5,096	98,516		98,516		98,516		11
12	Social Services	154,595	3,306	2,270	160,171		160,171		160,171		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,445,962	243,100	308,111	3,997,173	2,880	4,000,053		4,000,053		16
	C. General Administration										
17	Administrative	82,522		392,898	475,420	(115,837)	359,583		359,583		17
18	Directors Fees										18
19	Professional Services			25,895	25,895		25,895	(25,895)			19
20	Dues, Fees, Subscriptions & Promotions			79,558	79,558		79,558	(48,317)	31,241		20
21	Clerical & General Office Expenses	217,256	55,787	378,639	651,682		651,682	(48,945)	602,737		21
22	Employee Benefits & Payroll Taxes			929,902	929,902	65,100	995,002		995,002		22
23	Inservice Training & Education			4,703	4,703		4,703		4,703		23
24	Travel and Seminar			16,639	16,639		16,639		16,639		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			249,148	249,148		249,148		249,148		26
27	Other (specify):*										27
28	TOTAL General Administration	299,778	55,787	2,077,382	2,432,947	(50,737)	2,382,210	(123,157)	2,259,053		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,257,388	621,806	2,656,628	7,535,822	(37,834)	7,497,988	(133,821)	7,364,167		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 Champaign

#0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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			236,262	236,262	17,406	253,668		253,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(3,699)	(3,699)	20,428	16,729		16,729			32
33	Real Estate Taxes			60,869	60,869		60,869		60,869			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			145,632	145,632		145,632		145,632			35
36	Other (specify):*											36
37	TOTAL Ownership			439,064	439,064	37,834	476,898		476,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,588	3,588		3,588		3,588			38
39	Ancillary Service Centers		385,116		385,116		385,116		385,116			39
40	Barber and Beauty Shops			13,006	13,006		13,006		13,006			40
41	Coffee and Gift Shops	51,549			51,549		51,549		51,549			41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):* IV Ther, Xray, & Lab		209,598	99,822	309,420		309,420		309,420			43
44	TOTAL Special Cost Centers	51,549	594,714	172,261	818,524		818,524		818,524			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,308,937	1,216,520	3,267,953	8,793,410		8,793,410	(133,821)	8,659,589			45

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

Heartland of Champaign

ID# 0049395

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,322)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(1,322)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Champaign# 0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(10,664)	0	0	0	0	0	0	0	0	0	0	(10,664)	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	(10,664)	0	(10,664)	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	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	(25,895)	0	0	0	0	0	0	0	0	0	0	(25,895)	19
20	Fees, Subscriptions & Promotions	(48,317)	0	0	0	0	0	0	0	0	0	0	(48,317)	20
21	Clerical & General Office Expenses	(48,945)	0	0	0	0	0	0	0	0	0	0	(48,945)	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	(123,157)	0	(123,157)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(133,821)	0	(133,821)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Champaign# 0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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)	(133,821)	0	0	0	0	0	0	0	0	0	0	(133,821)	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
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	\$ 392,898	HCR Manor Care, Inc.	100.00%	\$ 392,898	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V	10a	29,494	Heartland Management Services	100.00%	29,494		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 422,392			\$ 422,392	\$ *	14

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 Champaign

0049395

Report Period Beginning:

06/01/09

Ending: 05/31/10

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 Street

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 NFs	\$ 2,826,629	\$ 1,585,087	7,927,588	\$ 7,841	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			7,927,588	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs,HHs, Rehab			7,927,588	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs			7,927,588	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			7,927,588	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	911,333		7,927,588	2,182	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	7,927,588	1,755	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			7,927,588	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	469,810		7,927,588	1,125	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		7,927,588	98,531	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	1,045,204		7,927,588	11,986	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	69,554,530	79,745,671	7,927,588	166,544	12
13	22	Empl Bnfts -Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		7,927,588	17,308	13
14	22	Empl Bnfts -Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	2,434,366		7,927,588	27,917	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	8,300,418		7,927,588	19,875	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714		7,927,588	285	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	43,612		7,927,588	500	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	6,941,685		7,927,588	16,621	18
19										19
20	32	Directly Assigned Interest				21,122,019			20,428	20
21		Non Central Div Nrsg Hm				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 392,898	25

Facility Name & ID Number

Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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			
A. Directly Facility Related																			
Long-Term																			
1		X	Various			\$ 802,268	\$ 802,268		0.0255	\$ 20,428	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8										(3,699)	8								
9						\$ 802,268	\$ 802,268			\$ 16,729	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14						\$	\$			\$	14								
15						\$ 802,268	\$ 802,268			\$ 16,729	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 bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2009 report.		\$	60,570	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.)		\$	60,670	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	100	3															
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,769	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.		\$	60,869	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2005	<u>48,924</u>	<u>8</u>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2009 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2009 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2006	<u>50,018</u>	<u>9</u>																
	2007	<u>52,976</u>	<u>10</u>																
	2008	<u>60,570</u>	<u>11</u>																
	2009	<u>60,769</u>	<u>12</u>																
Line 2: \$60,669.72 = \$30,384.69 for 1st half 2009 + \$30,285.03 for 2nd half 2008																			
Line 4: \$60,769 = \$25,320.58 for Jan - May 2010 + \$30,384.69 2nd half 2009 + \$5,064.12 for June 2009																			

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 Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,745 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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).

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>1968</u>	\$ <u>54,050</u>	<u>1</u>
2			<u>2007</u>	<u>249,936</u>	<u>2</u>
3	TOTALS			\$ 303,986	3

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	102			1968	\$ 1,201,229	\$ (11,217)		\$ (11,217)	\$	\$ 1,322,611	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					142,177		142,177		2,039,105	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1987	(55,068)						13
14				1988	41,139						14
15				1989	1,297						15
16				1990	20,319						16
17				1991	50,575						17
18				1992	374,174						18
19		RETIREMENTS		1992	(6,784)						19
20				1993	51,354						20
21				1994	48,400						21
22				1995	229,982						22
23		ELECTRICAL WORK		1996	17,102						23
24		WALL VINYL		1996	10,548						24
25		VINYL FLOORING		1996	14,858						25
26		INSTALL CAMERA SYSTEM		1996	1,453						26
27		REMODEL 13 ROOMS AND LOBBY		1996	35,665						27
28		HVAC		1996	21,101						28
29		ROOF WORK		1996	1,365						29
30		CORPORATE OVERHEAD-13 ROOMS/LOBBY		1996	7,272						30
31		CONCRETE WORK		1996	3,880						31
32		CARPET		1996	5,900						32
33		DIGITAL KEYPAD		1996	1,915						33
34		INSTALL EMERGENCY GENERATOR		1996	44,791						34
35		INSTALL CIRCUIT BREAKER		1996	3,289						35
36		HVAC		1996	1,867						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 Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	INSTALL COVE BASE/SIGNS	1996	\$ 2,612	\$		\$	\$	\$	37
38	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)						38
39	WALLCOVERINGS	1997	12,165						39
40	CARPET	1997	1,639						40
41	INSTALL HYDROLIC CYLINDER	1997	14,249						41
42	UNIT PROTECTION SWITCH	1997	6,354						42
43	FURNISH/INSTALL TILES	1997	16,476						43
44	HANDRAILS	1997	5,661						44
45	PLUMBING	1997	7,610						45
46	VINYL TILE	1997	1,643						46
47	HAND RAILS	1997	1,450						47
48	FACILITY PLAN ALLOC	1997	2,759						48
49	INSTALL GATES	1997	1,226						49
50	CORNER GUARDS	1997	314						50
51	C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)						51
52	ELECTRICAL	1998	2,598						52
53	REPLACE WINDOWS	1998	2,763						53
54	INSTALL QUARRY TILE	1998	1,640						54
55	INSTALL DUCTWORK	1998	2,350						55
56	CORPORATE OVERHEAD	1998	1,702						56
57	SECURITY SYSTEM	1998	33,542						57
58	ENTRYWAY/PARKING LOT WORK	1998	2,209						58
59	ELEVATOR EQUIP EVAL	1998	700						59
60	CARPENTRY	1998	355						60
61	WALLPAPER	1998	400						61
62	CARPETING/FLOORING	1998	2,471						62
63	PLUMBING	1998	9,690						63
64	ELECTRICAL	1998	1,367						64
65	HVAC	1998	565						65
66	PAINTING/WALLCOVERING	1998	10,552						66
67	GENERAL REQ	1998	1,500						67
68	CONTRACTORS	1998	2,507						68
69	ROOFING	1998	500						69
70	TOTAL (lines 4 thru 69)		\$ 2,355,636	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	70

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

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		\$ 2,355,636	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	1
2	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)						2
3	DOOR/WINDOW	1998	2,456						3
4	ELEVATORS	1998	3,433						4
5	SIGNAGE	1998	11,862						5
6	CARPETING	1999	5,993						6
7	CALL LIGHT SYSTEM	1999	42,342						7
8	1997 BILLING FOR CONSTRUCTION	1999	20,476						8
9	INSTALL SECURE DOOR KIT	1999	3,753						9
10	FABRIC FOR PATIENT FURNITURE	1999	121						10
11	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(121)						11
12	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						12
13	FABRIC FOR PATIENT FURNITURE	1999	674						13
14	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(674)						14
15	PAINT, WALLPAPER, CORRIDOR	1999	8,471						15
16	FIRE-SMOKE DAMPERS	1999	(581)						16
17	REMODEL KITCHEN RECEPTACLES	1999	4,800						17
18	NEW SHOWER BASE	1999	6,870						18
19	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						19
20	CERAMIC TILE - 2 SHOWERS	1999	2,718						20
21	FIRE & SMOKE DAMPERS	1999	9,527						21
22	PROCARE 1000 NURSE CALL	1999	17,494						22
23	ZSN REPAIR	1999	1,307						23
24	DRAIN REPLACEMENT	2000	875						24
25	DRYWALL REPAIR	2000	600						25
26	CONTROL PANEL REPLACED	2000	984						26
27	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						27
28	WALLCOVERINGS	2000	364						28
29	VINYL WALLCOVERINGS	2000	1,662						29
30	WALLCOVERING	2000	1,566						30
31	CLOSET DOORS	2000	13,140						31
32	WALLCOVERING	2000	37						32
33	WALLCOVERING - DINING RM	2000	1,769						33
34	TOTAL (lines 1 thru 33)		\$ 2,521,510	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	34

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

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		\$ 2,521,510	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	1
2	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						2
3	CORNER GUARDS	2000	17						3
4	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						4
5	WALLCOVERING	2000	270						5
6	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						6
7	C/R 5/31/03 AUDIT ADJ #1a - Developers Cost	2000	(4,708)						7
8	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						8
9	VCT	2000	3,230						9
10	WIRING - ACTIVITY & REC RM	2000	1,412						10
11	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						11
12	PAINTING CLOSET DOORS	2000	8,000						12
13	SINK, FAUCET & PLUMBING	2000	1,985						13
14	ARCADIA HALL BATH	2000	3,933						14
15	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						15
16	CLOSET DOORS	2000	7,640						16
17	SHOWER-CERAMIC TILE	2000	302						17
18	CLOSET DOOR - RETAINAGE	2000	1,460						18
19	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						19
20	2 NURSE STATIONS	2001	12,826						20
21	BORDER	2001	210						21
22	VCT	2001	1,130						22
23	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						23
24	DOORS	2001	8,985						24
25	CARPET	2001	1,053						25
26	CEILING TILE	2001	28,650						26
27	SHOWER RENOVATION	2001	13,048						27
28	PAINTING	2001	765						28
29	COURTYARD RENOVATIONS	2001	4,775						29
30	COURTYARD RENOVATIONS	2001	5,120						30
31	DOORS	2002	746						31
32	CARPET	2002	995						32
33	WALL TILE FOR SHOWER	2002	1,840						33
34	TOTAL (lines 1 thru 33)		\$ 2,645,205	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	34

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

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		\$ 2,645,205	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	1
2	MILLWORK, ELECTRICAL	2002	14,351						2
3	CARPET	2002	1,686						3
4	Freight on Carpet	2002	73						4
5	VWC	2002	282						5
6	3 Heavy Duty Doors	2002	3,574						6
7	C/R 5/31/03 AUDIT ADJ #1b - Overhead & Interest	2002	(5,444)						7
8	Painting, VWC, and Flooring	2002	1,098						8
9	Painting, VWC, and Flooring	2002	524						9
10	Renovation - Electrical 5/31/03 Audit Adj #2a Change Year	2002	87,505						10
11	Arch Engineering Costs	2002	1,018						11
12	freight on vwc	2002	9						12
13	general construction	2002	1,169						13
14	Freight on Carpet	2002	112						14
15	Carpet	2002	1,170						15
16	border	2002	1,254						16
17	freight on vwc	2002	20						17
18	carpet	2002	953						18
19	carpet and installation	2002	16,878						19
20	VWC	2002	140						20
21	carpet	2002	953						21
22	paint, vwc, and flooring	2002	9,357						22
23	Retro Addition	2002	(231)						23
24	VWC	2003	2,980						24
25	Flooring	2003	445						25
26	Reno - Gen, fire, Doors&P Audit Adj #2b Change Yr 2001 & 2002	2003	60,845						26
27	C/R 5/31/03 AUDIT ADJ #2b - Overhead & Interest	2003	(60,845)						27
28	Renovation - 5/31/03 Audit Adj #2b Change Year 2001	2001	88,776						28
29	Renovation - 5/31/03 Audit Adj #2b Change Year 2002	2002	6,593						29
30	Arch Engineering Costs	2003	172						30
31	Arch Engineering Costs	2003	774						31
32	Carpet	2003	140						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,881,535	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	34

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

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		\$ 2,881,535	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	1
2	CARPET	2003	1,075						2
3	ELEVATORS - OVERHEAD AND INTEREST	2003	3,300						3
4	ELEVATORS CARPENTRY	2003	72,624						4
5	BORDERS	2003	127						5
6	VWC	2003	438						6
7	VWC	2003	4,080						7
8	VWC	2003	571						8
9	CARPET AND INSTALLATION	2003	4,190						9
10	SHOWER ROOM FLOORS AND WALLS	2003	6,901						10
11	SHOWER ROOM FLOORS AND WALLS	2003	289						11
12	DEVELOPERS COSTS - OVERHEAD	2004	17,971						12
13	DEVELOPERS COSTS - INTEREST	2004	1,099						13
14	CARPETING AND PADS	2004	7,249						14
15	WALLCOVERINGS	2004	46,392						15
16	EXTERIOR LIGHT POLE	2004	6,596						16
17	EXTERIOR LIGHT POLE	2004	687						17
18	CONCRETE SLAB	2005	3,115						18
19	VINYL WALL COVERING	2004	1,377						19
20	VINYL WALL COVERING AND PAINTING	2004	9,000						20
21	VINYL WALL COVERING	2004	938						21
22	VINYL WALL COVERING & PAINTING	2004	1,380						22
23	VINYL WALL COVERING & PAINTING	2004	3,420						23
24	COVE BASE	2004	2,160						24
25	DOORS	2004	5,893						25
26	CARPET	2004	4,275						26
27	INSTALL SECURITY DOOR	2005	2,910						27
28	FOURTEEN ARTWORK PIECES	2004	1,117						28
29	ELECTRICAL WORK	2005	5,926						29
30	STAIR TREDS	2005	5,640						30
31	OVERHEAD	2005	13,558						31
32	INTEREST	2005	805						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,116,638	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	34

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

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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 12E, Carried Forward		\$ 3,116,638	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	1
2	FLOORING	2005	8,770						2
3	WALL COVERING	2005	8,050						3
4	CARPENTRY	2005	1,012						4
5	FENCE	2006	5,140						5
6	FENCE	2006	882						6
7	CERAMIC TILE SHOWER	2006	3,949						7
8	CHAMPAIGN IL	2007	2,550						8
9	SIDEWALK	2008	11,430						9
10	Blgd Im - Arch & Eng Fees	2007	53,414						10
11	Blgd Im - Arch & Eng Fees	2007	205,493						11
12	WALLPAPER	2007	6,605						12
13	CEILING TILES	2007	22,683						13
14	ENGINEERING	2007	17,000						14
15	ROOF REPLACEMENT	2007	66,406						15
16	COMMON AREA FURNISHINGS	2007	316						16
17	COMMON AREA FURNISHINGS	2008	1,605						17
18	CARPET FOR 2ND/3RD FLOOR	2008	26,122						18
19	CARPET FOR 2ND/3RD FLOOR	2008	(1)						19
20	FIRE DAMPERS	2008	75,045						20
21	Renov -(Tot contracted amt) -Painting, Drywall, VWC	2009	10,350						21
22	CARPETING+PADS	2008	9,317						22
23	PAVING/SEALCOATING	2008	5,949						23
24	SEWER LINE	2009	13,911						24
25	Add'l cost Fire Dampers	2008	5,587						25
26	Fir Dampers	2008	50,285						26
27	Kitchen Storage Room Door	2009	5,283						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,733,791	\$ 130,960		\$ 130,960	\$	\$ 3,361,716	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	\$ 1,582,901	\$ 105,302	\$ 105,302	\$		\$ 1,217,202	71
72	Current Year Purchases	16,294						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			17,406	17,406			74
75	TOTALS	\$ 1,599,195	\$ 105,302	\$ 122,708	\$ 17,406		\$ 1,217,202	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)	\$ 5,636,972	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,262	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,668	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,406	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,578,918	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$ _____			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? _____

YES NO

16. Rental Amount for movable equipment: \$ 112,812 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. 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	Patient Transportation		\$ _____	\$ <u>32,820</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>32,820</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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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	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	3972 hrs	\$ 139,897		\$	\$ 2,405	3,972	\$ 142,302	1
2	Licensed Speech and Language Development Therapist	10a	2813 hrs	106,431				2,813	106,431	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4279 hrs	157,609			11,912	4,279	169,521	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 prescripts				209,598		209,598	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>PS Inhal, Xray & Lab</u>	10a & 43, 2	406	21,928			99,822	406	121,750	13
14	TOTAL			\$ 425,865		\$	\$ 323,737	11,470	\$ 749,602	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 Champaign# 0049395Report Period Beginning: 06/01/09Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10

(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	\$ 19,427	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (400,494))	1,385,531		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,120		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,408,078	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,986		13
14	Buildings, at Historical Cost	3,733,790		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,599,196		16
17	Accumulated Depreciation (book methods)	(4,578,918)		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>	29,807		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,087,861	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,495,939	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 172,027	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	453,577		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,705		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	41,697		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 723,006	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	802,268		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 802,268	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,525,274	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 970,665	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,495,939	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 899,430	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 899,430	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,036,923	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)	\$ 1,036,923	17
	B. Transfers (Itemize):		
18	Change in interdivision	(965,688)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (965,688)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 970,665	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Champaign# 0049395Report Period Beginning: 06/01/09Ending: 05/31/10

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	\$ 9,833,118	1
2	Discounts and Allowances for all Levels	(3,352,106)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,481,012	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,670,137	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,670,137	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	1,353	12
13	Barber and Beauty Care	2,573	13
14	Non-Patient Meals	10,664	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	396,434	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	112,027	19
20	Radiology and X-Ray	88,164	20
21	Other Medical Services	67,969	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 679,184	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,830,333	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,105,702	31
32	Health Care	3,997,173	32
33	General Administration	2,432,947	33
B. Capital Expense			
34	Ownership	439,064	34
C. Ancillary Expense			
35	Special Cost Centers	762,679	35
36	Provider Participation Fee	55,845	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,793,410	40
41	Income before Income Taxes (line 30 minus line 40)**	1,036,923	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,036,923	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 Champaign

0049395

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	2,553	2,794	\$ 94,570	\$ 33.85	1
2	Assistant Director of Nursing	9,572	10,474	270,495	25.83	2
3	Registered Nurses	12,375	13,541	342,963	25.33	3
4	Licensed Practical Nurses	26,010	28,461	585,655	20.58	4
5	CNAs & Orderlies	73,686	80,814	980,851	12.14	5
6	CNA Trainees					6
7	Licensed Therapist	12,770	14,003	526,365	37.59	7
8	Rehab/Therapy Aides	13,311	14,597	350,970	24.04	8
9	Activity Director	6,033	6,619	81,862	12.37	9
10	Activity Assistants					10
11	Social Service Workers	7,633	8,374	154,595	18.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,499	22,510	253,550	11.26	15
16	Dishwashers					16
17	Maintenance Workers	4,368	4,792	85,839	17.91	17
18	Housekeepers	9,538	10,467	117,223	11.20	18
19	Laundry	3,747	4,113	55,036	13.38	19
20	Administrator	2,080	2,080	82,522	39.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,940	12,045	217,256	18.04	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	3,622	3,974	57,636	14.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	3,825	4,197	51,549	12.28	33
34	TOTAL (lines 1 - 33)	222,562	243,855	\$ 4,308,937 *	\$ 17.67	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 36,000	5,9	36
37	Medical Records Consultant	Monthly 2,274	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,952	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) <u>Medical Svcs</u>	Monthly 75,373	10,3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 115,599		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Pamella Britt</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 82,522</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 165,021</u>	<u>IDPH License Fee</u>	<u>\$ 3,440</u>	
				<u>Unemployment Compensation Insurance</u>	<u>42,457</u>	<u>Advertising: Employee Recruitment</u>	<u>13,081</u>	
				<u>FICA Taxes</u>	<u>308,210</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>357,914</u>	<u>(Indicate # of checks performed <u>13</u>)</u>	<u>5,071</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>3,640</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>2,283</u>	
				<u>Employee Appreciation</u>		<u>Association Dues</u>	<u>7,949</u>	
				<u>401K</u>	<u>36,691</u>	<u>Advertising</u>	<u>44,094</u>	
				<u>Other Employee Benefits</u>	<u>11,719</u>	<u>Public Relations</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 82,522	<u>Tuition Program</u>	<u>558</u>	<u>Less: Non-Allowable Association Dues</u>	<u>(4,223)</u>	
(List each licensed administrator separately.)				<u>SMSP Match</u>		<u>Less: Public Relations Expense</u>	<u>(</u>	
				<u>Employee Uniforms</u>	<u>7,332</u>	<u>Non-allowable advertising</u>	<u>(44,094)</u>	
				<u>Home Office Allocation</u>	<u>65,100</u>	<u>Yellow page advertising</u>	<u>(</u>	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,241	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 995,002			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees</u>			<u>\$ 392,898</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	<u>16,639</u>
							<u>Includes travel expense to the Home Office in Toledo, OH for regional meetings.</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 392,898				<u>Seminar Expense</u>	
(Attach a copy of any management service agreement)								
							<u>Entertainment Expense</u>	<u>(</u>
C. Professional Services				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 16,639
Vendor/Payee	Type		Amount					
<u>Michael T. Mahoney, LTD</u>	<u>Legal</u>		<u>\$ 2,601</u>					
<u>United Collection Bureau Inc.</u>	<u>Fees for Collections</u>		<u>23,294</u>					
<u>Legal fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no legal invoices are attached.</u>								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 25,895					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning: 06/01/09

Ending: 05/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICHA \$3,726
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$4223
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,003 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. \$ 55,845
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. \$ 10,664
- (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.