

Facility Name & ID Number Heartland of Normal

0049536 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>116</u>	Skilled (SNF)	<u>116</u>	<u>42,340</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>116</u>	TOTALS	<u>116</u>	<u>42,340</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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>7,144</u>	<u>9,708</u>	<u>16,935</u>	<u>33,787</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>7,144</u>	<u>9,708</u>	<u>16,935</u>	<u>33,787</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.80%

D. How many bed-hold days during this year were paid by the Department?

4 (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 116 and days of care provided 12,778

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: 05/31

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

Facility Name & ID Number Heartland of Normal # 0049536 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	216,939	21,269	86,208	324,416	7,723	332,139		332,139		1
2	Food Purchase		238,787		238,787		238,787	(644)	238,143		2
3	Housekeeping	122,777	17,883	1,845	142,505		142,505		142,505		3
4	Laundry	38,301	13,100	2,114	53,515		53,515	(4)	53,511		4
5	Heat and Other Utilities			198,658	198,658	2,149	200,807		200,807		5
6	Maintenance	41,425	20,039	91,526	152,990		152,990		152,990		6
7	Other (specify):* Medical Waste			1,815	1,815		1,815		1,815		7
8	TOTAL General Services	419,442	311,078	382,166	1,112,686	9,872	1,122,558	(648)	1,121,910		8
	B. Health Care and Programs										
9	Medical Director			29,644	29,644		29,644		29,644		9
10	Nursing and Medical Records	2,304,696	205,297	64,078	2,574,071	2,837	2,576,908	(5,412)	2,571,496		10
10a	Therapy	901,244	9,360	66,525	977,129		977,129		977,129		10a
11	Activities	45,276	2,778	2,905	50,959		50,959		50,959		11
12	Social Services	107,978	2	1,739	109,719		109,719		109,719		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,359,194	217,437	164,891	3,741,522	2,837	3,744,359	(5,412)	3,738,947		16
	C. General Administration										
17	Administrative	143,285		409,358	552,643	(136,459)	416,184		416,184		17
18	Directors Fees										18
19	Professional Services			25,738	25,738	(2,989)	22,749	(22,749)			19
20	Dues, Fees, Subscriptions & Promotions			92,809	92,809		92,809	(50,243)	42,566		20
21	Clerical & General Office Expenses	250,698	51,657	(9,630)	292,725	2,989	295,714	102,720	398,434		21
22	Employee Benefits & Payroll Taxes			916,519	916,519	64,122	980,641		980,641		22
23	Inservice Training & Education			4,033	4,033		4,033		4,033		23
24	Travel and Seminar			25,309	25,309		25,309		25,309		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			280,853	280,853		280,853		280,853		26
27	Other (specify):*										27
28	TOTAL General Administration	393,983	51,657	1,744,989	2,190,629	(72,337)	2,118,292	29,728	2,148,020		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,172,619	580,172	2,292,046	7,044,837	(59,628)	6,985,209	23,668	7,008,877		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 Normal

#0049536

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			274,487	274,487	17,146	291,633		291,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(11,159)	(11,159)	42,482	31,323		31,323			32
33	Real Estate Taxes			63,886	63,886		63,886		63,886			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			170,423	170,423		170,423		170,423			35
36	Other (specify):*											36
37	TOTAL Ownership			497,637	497,637	59,628	557,265		557,265			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,385	3,385		3,385		3,385			38
39	Ancillary Service Centers		432,508		432,508		432,508		432,508			39
40	Barber and Beauty Shops		71	16,305	16,376		16,376		16,376			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):* IV X-Ray & Lab		54,816	142,343	197,159		197,159		197,159			43
44	TOTAL Special Cost Centers		487,395	225,543	712,938		712,938		712,938			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,172,619	1,067,567	3,015,226	8,255,412		8,255,412	23,668	8,279,080			45

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

Heartland of Normal

ID# 0049536

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,653)	21	1
2	Misc. Income	0	21	2
3	Activity Income	0	11	3
4	Loss on Disposal of Fixed Assets	0	36	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
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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	(1,653)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Normal

0049536

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(644)	0	0	0	0	0	0	0	0	0	0	(644)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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	(648)	0	0	0	0	0	0	0	0	0	0	(648)	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	(5,412)	0	0	0	0	0	0	0	0	0	0	(5,412)	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	(5,412)	0	0	0	0	0	0	0	0	0	0	(5,412)	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	(22,749)	0	0	0	0	0	0	0	0	0	0	(22,749)	19
20	Fees, Subscriptions & Promotions	(50,243)	0	0	0	0	0	0	0	0	0	0	(50,243)	20
21	Clerical & General Office Expenses	102,720	0	0	0	0	0	0	0	0	0	0	102,720	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	29,728	0	0	0	0	0	0	0	0	0	0	29,728	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	23,668	0	0	0	0	0	0	0	0	0	0	23,668	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Normal# 0049536

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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	23,668	0	0	0	0	0	0	0	0	0	0	23,668	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)				

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	\$ 409,358	HCR Manor Care, Inc.	100.00%	\$ 409,358	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	32,389	Heartland Rehab Services, LLC	100.00%	32,389		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 441,747			\$ 441,747	\$ *	14

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

Facility Name & ID Number Heartland of Normal # 0049536 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 Normal

0049536

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 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 NFs	\$ 2,826,629	\$ 1,585,087	7,808,543	\$ 7,723	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	7,808,543	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	0	0	7,808,543	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	0	0	7,808,543	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	7,808,543	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	911,333	0	7,808,543	2,149	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	7,808,543	1,729	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	7,808,543	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	469,810	0	7,808,543	1,108	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	35,518,981	0	7,808,543	97,052	10
11	17	General & Admin - Direct to Cent	Accumulated Cost	691,284,298	95NFs	1,045,204	0	7,808,543	11,806	11
12	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	69,554,530	79,745,671	7,808,543	164,041	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	6,239,311	0	7,808,543	17,048	13
14	22	Employee Benefits - Direct to Cent	Accumulated Cost	691,284,298	95NFs	2,434,366	0	7,808,543	27,498	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	8,300,418	0	7,808,543	19,576	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714	0	7,808,543	281	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95NFs	43,612	0	7,808,543	493	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	6,941,685	0	7,808,543	16,372	18
19										19
20	32	Directly Assigned Interest				21,122,019			42,482	20
21		Non Central Division Nursing Home Allocation				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 409,358	25

Facility Name & ID Number

Heartland of Normal

0049536

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	Conv. Sub Debentures		X	Various				\$ 1,668,364	\$ 1,668,364		2.5463	\$ 42,482	1						
2													2						
3													3						
4													4						
5													5						
Working Capital																			
6													6						
7													7						
8	Interest Income Other											(11,159)	8						
9	TOTAL Facility Related						\$ 1,668,364	\$ 1,668,364				\$ 31,323	9						
B. Non-Facility Related*																			
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$				\$	14						
15	TOTALS (line 9+line14)						\$ 1,668,364	\$ 1,668,364				\$ 31,323	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.	\$	64,083	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.)	\$	32,042	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(32,041)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	95,927	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.	\$	63,886	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	55,750	8
	2006	59,079	9
	2007	61,611	10
	2008	64,083	11
	2009	67,713	12

Line 2: \$32,042 = \$32,042 for 2nd half of 2008 paid in Sept. '09.

Line 4: \$95,927 = \$33,857 1st half 2009 + \$33,856 2nd half 2009 + \$28,214 estimate for Jan-May 2010.

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

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 Normal

0049536

Report Period Beginning:

06/01/09

Ending:

05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,829 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>1971</u>	\$ <u>58,339</u>	<u>1</u>
2			<u>1993 & 2001</u>	<u>130,541</u>	<u>2</u>
3	TOTALS			\$ 188,880	3

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	90		1971	1962	\$ 506,817	\$ 11,167		\$ 11,167		\$ 1,194,348	4
5	9			1994	497,564						5
6	10			2001	533,510						6
7	7			2006	480,167						7
8	Dining Room			2010	233,277						8
Improvement Type**											
9	Current Year Depreciation					141,700		141,700		2,415,305	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18	RETIREMENTS			1987	(29,830)						18
19				1988	207,264						19
20				1989	134,621						20
21				1990	46,332						21
22				1991	15,386						22
23				1992	57,357						23
24	RETIREMENTS			1992	(3,110)						24
25				1993	44,829						25
26				1994	137,130						26
27				1995	72,481						27
28	RENOVATIONS-PATIENT ROOMS			1996	22,684						28
29	CARPET/TILE & INSTALLATION			1996	4,392						29
30	CAPITALIZED LABOR			1996	7,272						30
31	WALL VINYL/DRYWALL			1996	5,194						31
32	SIGNS/BOARDS			1996	1,730						32
33	INSTALL GRID/PANELS			1996	4,402						33
34	CONCRETE WALK/RAMP			1996	2,850						34
35	CABINETS			1996	1,087						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Normal

0049536

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	CARPETING	1996	\$ 9,845	\$		\$	\$	\$	37
38	ROOFING	1996	24,474						38
39	ELECTRICAL/LIGHTING	1996	2,159						39
40	WALLCOVERINGS	1996	5,910						40
41	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						41
42	INSTALL SHOWER TILE	1996	2,656						42
43	REPAIR COMPRESSOR	1996	900						43
44	CONCRETE WALK	1996	1,053						44
45	CR5/31/99 AUDIT ADJ - CAPITAL	1996	(7,272)						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALLCOVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	PLUMBING/BATHROOM WORK	1997	1,226						55
56	ELECTRICAL	1997	2,416						56
57	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						57
58	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						58
59	FINISH/STUD	1998	4,865						59
60	PAINTING/WALLCOVERINGS	1998	8,175						60
61	CARPETING	1998	6,460						61
62	PLUMBING	1998	1,456						62
63	ROOFING	1998	2,170						63
64	DOORS/WINDOWS/CASEWORK	1998	9,884						64
65	ELECTRICAL	1998	5,360						65
66	FLOORING/CEILING/COVE BASE	1998	13,283						66
67	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						67
68	CORPORATE OVERHEAD-PATIENT ROOMS		1,702						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,724,503	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	70

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

Facility Name & ID Number Heartland of Normal

0049536

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		\$ 3,724,503	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	7/1/06 Capital Rate Adj	1998	2,520						17
18	GAZEBO	1998	2,495						18
19	7/1/06 Capital Rate Adj #2	1998	(2,495)						19
20	FLOORS	1999	2,990						20
21	DOORS	1999	18,097						21
22	FENCING	1999	4,343						22
23	SIDEWALK	1999	3,719						23
24	FIRE SPRINKLER	1999	6,270						24
25	WATER HEATER	1999	7,717						25
26	DOORS (adj yr per Capital Rate Adj #3)	1999	11,081						26
27	PAINTING (adj yr per Capital Rate Adj #4)	1999	28,868						27
28	FLOORS	2000	830						28
29	RENOVATION-ARCADIA ADDTN	2000	5,000						29
30	CONCRETE	2000	1,685						30
31	CARPENTRY	2000	3,179						31
32	DRYWALL/FINISHES	2000	15,397						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,889,557	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	34

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

Facility Name & ID Number Heartland of Normal

0049536

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		\$ 3,889,557	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	CEILING / FLOORING	2000	5,680						2
3	CAREPTING & PADS	2000	7,167						3
4	WALLCOVERING	2000	7,060						4
5	ELECTRICAL	2000	12,505						5
6	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						6
7	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(25,528)						7
8	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						8
9	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(5,447)						9
10	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						10
11	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(43,193)						11
12	WATER HEATER	2001	9,350						12
13	8 REPLACEMENT WINDOWS	2001	5,812						13
14	MIXING VALVE	2001	3,397						14
15	CARPET & VWC	2001	24,531						15
16	7/1/06 Capital Rate Adj #5	2001	(21,937)						16
17	SOIL & CONCRETE TESTING	2001	2,905						17
18	WATER & SEWER, PERMIT FEES	2001	14,582						18
19	7/1/06 Capital Rate Adj #6	2001	(13,611)						19
20	SITWORK	2001	74,254						20
21	7/1/06 Capital Rate Adj #7	2001	(74,254)						21
22	LANDSCAPING	2001	2,270						22
23	ADDITIONAL COST SITWORK	2001	371						23
24	7/1/06 Capital Rate Adj #8	2001	(371)						24
25	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #9)	2001	10,290						25
26	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #10)	2001	8,731						26
27	FRONT HALL & OFFICE WALLS / FLOORS	2002	29,012						27
28	FRONT HALL & OFFICE WALLS / FLOORS	2002	4,580						28
29	FLOORING BY GREASE TRAP	2002	753						29
30	FLOORING	2002	5,415						30
31	ADDITIONAL ARCHITECTURE ENG.	2002	65						31
32	ARCHITECTURE ENGINEERING	2002	350						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,008,464	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	34

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

Facility Name & ID Number Heartland of Normal

0049536

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		\$ 4,008,464	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	ARCHITECTURE ENGINEERING	2002	2,993						2
3	DIETARY HVAC	2002	82,214						3
4	7/1/06 Capital Rate Adj #11	2002	(21,512)						4
5	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						5
6	7/1/06 Capital Rate Adj #12	2002	(7,395)						6
7	SMOKE SHELTER	2002	3,540						7
8	ALUMINUM SHELTER	2002	5,225						8
9	SIDEWALK	2002	2,375						9
10	FENCE	2002	975						10
11	RETROACTIVE ADDITION	2002	(10)						11
12	7/1/06 Capital Rate Adj	2002	10						12
13	LANDSCAPING	2003	7,887						13
14	DEVELOPERS COST - OVERHEAD	2003	10,184						14
15	7/1/06 Capital Rate Adj #13	2003	(10,184)						15
16	INTEREST ON CONSTRUCTION	2003	722						16
17	7/1/06 Capital Rate Adj #14	2003	(722)						17
18	CARPENTRY	2003	3,460						18
19	FLOORING	2003	7,040						19
20	PAINTING	2003	33,211						20
21	WALLCOVERING	2003	6,434						21
22	HVAC	2003	3,587						22
23	VWC	2003	754						23
24	HANDRAILS & INSTALLATION	2003	2,300						24
25	VWC	2004	922						25
26	BORDER	2004	56						26
27	PAINT, VWC & BORDER	2004	1,300						27
28	CABINETS AND COUNTERTOPS	2004	5,671						28
29	FLOORING	2004	2,288						29
30	FLOORING	2004	7,170						30
31	PAINT & VWC	2004	7,200						31
32	CARPET	2004	868						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,174,423	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	34

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

Facility Name & ID Number Heartland of Normal

0049536

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		\$ 4,174,423	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	OVERLAY ASPHALT PARKING LOT	2004	9,662						2
3	PARKING LOT CONSTRUCTION AND PAVING (Cap Adj #15)	2004	55,622						3
4	PAINT & VINYL WALL COVERING	2004	1,189						4
5	PAINT & VINYL WALL COVERING	2004	3,497						5
6	VINYL WALL COVERING	2004	219						6
7	DOOR WITH LOCK	2004	3,461						7
8	EXIT PANEL	2004	1,995						8
9	VINYL COVERED TILE	2004	640						9
10	PAINTING	2004	1,450						10
11	VINYL WALL COVERING	2004	432						11
12	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						12
13	7/1/06 Capital Rate Adj #16	2004	(34,924)						13
14	ELECTRICAL WORK	2004	30,627						14
15	VINYL WALL COVERING	2004	56						15
16	VINYL COVERED TILE AND COVE BASE	2004	2,175						16
17	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						17
18	ELECTRICAL WORK	2004	4,342						18
19	ELECTRICAL WORK	2004	8,455						19
20	VINYL WALL COVERING	2004	1,279						20
21	13 PHONE LINES & JACKS	2004	3,520						21
22	ENGINEERING, OVERHEAD & INTEREST	2005	9,557						22
23	7/1/06 Capital Rate Adj #17	2005	(9,557)						23
24	VINYL WALL COVERING	2005	1,279						24
25	7/1/06 Capital Rate Adj #18	2005	(1,279)						25
26	VINYL WALL COVERING	2005	506						26
27	VINYL WALL COVERING	2005	526						27
28	VINYL WALL COVERING	2005	159						28
29	VINYL WALL COVERING	2005	257						29
30	VINYL WALL COVERING	2005	7,268						30
31	VINYL WALL COVERING	2005	2,749						31
32	VINYL WALL COVERING	2005	2,670						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,325,865	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	34

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

Facility Name & ID Number Heartland of Normal

0049536

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		\$ 4,325,865	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	VINYL WALL COVERING	2005	2,510						2
3	FLOORING VINYL	2005	1,980						3
4	KICK RAIL	2005	2,354						4
5	WINDOW TREATMENTS	2005	5,098						5
6	VINYL COVERED TILE & CARPET	2005	9,340						6
7	DOOR	2005	1,580						7
8	CEILING TILE	2005	29,500						8
9	OVERHEAD & INTEREST	2005	18,308						9
10	7/1/06 Capital Rate Adj #19	2005	(18,308)						10
11	ROOFING & SHEET METAL	2005	237,310						11
12	DUCT WORK	2005	6,802						12
13	SITE PREP, LANDSCAPING, UTILITIES	2006	52,007						13
14	SOIL & CONCRETE TESTING	2006	2,435						14
15	ELECTRICAL POWER SUPPLY	2006	2,295						15
16	ARCHITECT & ENGINEERING COSTS	2006	85,271						16
17	GENERAL OVERHEAD & INTEREST	2006	46,990						17
18	PLAN REVIEWS	2006	8,192						18
19	WALLCOVERINGS	2006	9,806						19
20	MILLWORK	2006	1,766						20
21	DINING ROOM RAILS	2007	2,950						21
22	DINING ROOM PAINTING	2007	3,950						22
23	ARCHITECT & ENGINEERING COSTS	2007	3,662						23
24	GENERAL OVERHEAD & INTEREST	2007	11,136						24
25	RESILIENT FLOORING	2007	780						25
26	WALLCOVERINGS	2007	17,334						26
27	CARPENTRY	2007	29,147						27
28	DOORS & FRAMES	2007	17,334						28
29	2 ROOF TOP UNITS	2007	4,885						29
30	UTILITY RM IMPROVEMENTS	2007	4,900						30
31	2 ROOF TOP UNITS	2007	6,444						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,933,623	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	34

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

Facility Name & ID Number Heartland of Normal

0049536

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 12F, Carried Forward		\$ 4,933,623	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	1
2	000000001982 CARPET	2008	633						2
3	000000001984 NURSE STN, ADMIN OFF, MED RM RENVSTN	2008	22,232						3
4	000000001985 NURSE STATION CABINTRY	2008	17,892						4
5	000000001986 ADJ TO NURSE STATION (#1985)	2008	333						5
6	000000001987 RENOV CORR WALLS AND KITCH CEI	2008	6,850						6
7	000000001988 2 DOOR CLOSURES AND FRAMES	2009	12,974						7
8	000000001989 WALLCOVER PAINT EMPLOYEE HALLW	2009	5,175						8
9									9
10	New Sidewalks	2009	15,500						10
11	Renov. - Interior Demo & Renovations - Corridor Renovation	2009	83,910						11
12	Renov. - Resilient Flooring - Corridor Renovation	2009	14,912						12
13	Renov. - Carpeting & Pads - Corridor Renovation	2009	8,142						13
14	Renov. - Wallcovering & Corner Guards - Corridor Renovation	2009	50,857						14
15	Water Heaters (2) BTH-300A	2009	30,010						15
16	Concrete Flooring & Replace Under Floor Water Line	2009	4,050						16
17	New Copper Water Lines	2010	12,214						17
18	Dining Rm/Therapy-Site Prep, General Contractor	2010	21,798						18
19	Dining Rm/Therapy-Soil Tesing	2010	1,845						19
20	Dining Rm/Therapy-Arch & Engineer Cost	2010	64,025						20
21	Dining Rm/Therapy-Wallcovering	2010	1,864						21
22	Trench Box and New Gas Line	2010	4,043						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,312,882	\$ 152,867		\$ 152,867	\$	\$ 3,609,653	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	\$ 1,676,548	\$ 121,620	\$ 121,620	\$		\$ 1,363,347	71
72	Current Year Purchases	58,872						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			17,146	17,146			74
75	TOTALS	\$ 1,735,420	\$ 121,620	\$ 138,766	\$ 17,146		\$ 1,363,347	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)	\$ 7,237,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 274,487	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 291,633	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,146	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,973,000	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	\$ 71,823	92
93			93
94			94
95		\$ 71,823	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? _____

16. Rental Amount for movable equipment: \$ 135,553 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		\$ _____	\$ <u>34,870</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>34,870</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, 1	3157 hrs	\$ 121,430	389	\$ 21,029		3,546	\$ 142,459	1
2	Licensed Speech and Language Development Therapist	10a, 1	2213 hrs	85,128			424	2,213	85,552	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	7674 hrs	295,113	238	12,853	8,936	7,912	316,902	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				432,508		432,508	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>IV Theray</u>	43, 2					54,816		54,816	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3				142,343			142,343	13
14	TOTAL			\$ 501,671	627	\$ 176,225	\$ 496,684	13,671	\$ 1,174,580	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 Normal# 0049536Report 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	\$ 4,795	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>344,112</u>)	1,290,264		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,548		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,298,607	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,880		13
14	Buildings, at Historical Cost	5,312,882		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,735,420		16
17	Accumulated Depreciation (book methods)	(4,973,000)		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>	71,823		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,336,005	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,634,612	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 168,026	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	405,736		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,927		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	38,759		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 708,448	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,668,364		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)	\$ 1,668,364	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,376,812	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,257,800	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,634,612	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,414,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,414,783	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,576,245	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)	\$ 2,576,245	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(2,733,228)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,733,228)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,257,800	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Normal# 0049536Report 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	\$ 10,864,919	1
2	Discounts and Allowances for all Levels	(3,324,164)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,540,755	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,591,152	6
7	Oxygen	(8)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,591,144	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	1,880	12
13	Barber and Beauty Care	19,154	13
14	Non-Patient Meals	644	14
15	Telephone, Television and Radio	301	15
16	Rental of Facility Space		16
17	Sale of Drugs	451,689	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	99,657	19
20	Radiology and X-Ray	57,168	20
21	Other Medical Services	68,961	21
22	Laundry	4	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 699,458	23
D. Non-Operating Revenue			
24	Contributions	300	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 300	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts		28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,831,657	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,112,686	31
32	Health Care	3,741,522	32
33	General Administration	2,190,629	33
B. Capital Expense			
34	Ownership	497,637	34
C. Ancillary Expense			
35	Special Cost Centers	649,428	35
36	Provider Participation Fee	63,510	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,255,412	40
41	Income before Income Taxes (line 30 minus line 40)**	2,576,245	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,576,245	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 Normal

0049536

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	840	910	\$ 34,113	\$ 37.49	1
2	Assistant Director of Nursing	5,746	6,220	180,799	29.07	2
3	Registered Nurses	22,705	24,579	611,643	24.88	3
4	Licensed Practical Nurses	21,929	23,740	505,032	21.27	4
5	CNAs & Orderlies	75,770	82,231	945,565	11.50	5
6	CNA Trainees			0		6
7	Licensed Therapist	13,044	14,254	548,191	38.46	7
8	Rehab/Therapy Aides	13,876	15,163	353,053	23.28	8
9	Activity Director	3,687	4,002	45,276	11.31	9
10	Activity Assistants					10
11	Social Service Workers	5,405	5,876	107,978	18.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,078	21,816	216,939	9.94	15
16	Dishwashers					16
17	Maintenance Workers	1,797	1,950	41,425	21.24	17
18	Housekeepers	10,618	11,532	122,777	10.65	18
19	Laundry	3,829	4,161	38,301	9.20	19
20	Administrator	2,080	2,080	96,082	46.19	20
21	Assistant Administrator	1,952	1,952	47,203	24.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,731	16,051	250,698	15.62	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	1,910	2,074	27,544	13.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,997	238,591	\$ 4,172,619 *	\$ 17.49	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	29,644	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,220	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					47
48					48
49	TOTAL (lines 35 - 48)	\$	31,864		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	
Raymond Campbell (Jun'09-Aug'09)	Administrator	0	\$ 23,714	Workers' Compensation Insurance	\$ 244,302	IDPH License Fee	\$ 1,194	
David Sneddon (Sept '09-May '10)	Administrator	0	72,368	Unemployment Compensation Insurance	46,733	Advertising: Employee Recruitment	14,875	
Rachel Frantz-Cassell	Asst. Admin.	0	47,203	FICA Taxes	293,177	Health Care Worker Background Check	4,926	
				Employee Health Insurance	295,018	(Indicate # of checks performed <u>280</u>)		
				Employee Meals		<u>Patient Background Checks</u>	<u>337</u>	
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues & Subscriptions</u>	<u>5,605</u>	
				<u>Disability Payments</u>		<u>Association Dues</u>	<u>8,857</u>	
				<u>401K</u>	<u>15,382</u>	<u>Advertising</u>	<u>45,624</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 143,285	<u>Appreiation & Other Employee Benefits</u>	<u>9,103</u>	<u>Relocation</u>	<u>11,728</u>	
(List each licensed administrator separately.)				<u>Tuition Program</u>	<u>8,021</u>	<u>Less Non-allowable Association Dues</u>	<u>(4,619)</u>	
				<u>SMSP Match & RSU</u>		<u>Less: Public Relations Expense</u>	<u>()</u>	
B. Administrative - Other				<u>Employee Uniforms</u>	<u>4,783</u>	<u>Non-allowable advertising</u>	<u>(45,624)</u>	
				<u>Home Office Allocation</u>	<u>64,122</u>	<u>Yellow page advertising</u>	<u>()</u>	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 42,566	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 980,641			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 409,358	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Michael T. Mahoney, LTD	Legal Fees		\$ 3,215				In-State Travel	25,309
							Includes travel expense to the Home Office in Toledo, OH for regional meetings	
United Collection Bureau Inc.	Collection Services		19,534				Seminar Expense	
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)							Entertainment Expense	()
Corporate Intelligence Consultants	Theft investigation (reclass to line 21)		2,989					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 25,738	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 25,309
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Normal

0049536

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. IHCA \$4238
- (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
- (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. \$ 45,001 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. \$ 63,510
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. \$ 644
- (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.