

Facility Name & ID Number Heartland of Champaign

0049395 Report Period Beginning: 06/01/11 Ending: 05/31/12

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	102	Skilled (SNF)	102	37,332	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	102	TOTALS	102	37,332	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,590	9,627	12,724	26,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,590	9,627	12,724	26,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.17%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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 04/07/11 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 10,143

Medicare Intermediary Novitas Solutions

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 Champaign

0049395

Report Period Beginning:

06/01/11

Ending:

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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	211,686	26,451	82,680	320,817		320,817		320,817		1
2	Food Purchase		257,147		257,147		257,147	(12,611)	244,536		2
3	Housekeeping	106,147	13,552	6,878	126,577		126,577		126,577		3
4	Laundry	47,117	25,227	3,237	75,581		75,581		75,581		4
5	Heat and Other Utilities			148,577	148,577	1,929	150,506		150,506		5
6	Maintenance	55,751	22,438	141,307	219,496		219,496		219,496		6
7	Other (specify):* Med Waste			727	727		727		727		7
8	TOTAL General Services	420,701	344,815	383,406	1,148,922	1,929	1,150,851	(12,611)	1,138,240		8
	B. Health Care and Programs										
9	Medical Director			7,835	7,835		7,835		7,835		9
10	Nursing and Medical Records	2,129,994	212,035	134,787	2,476,816	12,174	2,488,990		2,488,990		10
10a	Therapy	961,388	9,631	58,294	1,029,313		1,029,313		1,029,313		10a
11	Activities	58,739	6,715	1,358	66,812		66,812		66,812		11
12	Social Services	134,422	96	2,921	137,439		137,439		137,439		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,284,543	228,477	205,195	3,718,215	12,174	3,730,389		3,730,389		16
	C. General Administration										
17	Administrative	82,998		454,759	537,757	(172,454)	365,303		365,303		17
18	Directors Fees										18
19	Professional Services			13,068	13,068	(1,605)	11,463	(11,463)			19
20	Dues, Fees, Subscriptions & Promotions			182,661	182,661		182,661	(136,029)	46,632		20
21	Clerical & General Office Expenses	309,451	52,309	324,848	686,608	1,605	688,213	(171,103)	517,110		21
22	Employee Benefits & Payroll Taxes			801,596	801,596	26,025	827,621		827,621		22
23	Inservice Training & Education			5,930	5,930		5,930		5,930		23
24	Travel and Seminar			13,492	13,492		13,492		13,492		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			312,307	312,307		312,307		312,307		26
27	Other (specify):*							(90)	(90)		27
28	TOTAL General Administration	392,449	52,309	2,108,661	2,553,419	(146,429)	2,406,990	(318,685)	2,088,305		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,097,693	625,601	2,697,262	7,420,556	(132,326)	7,288,230	(331,296)	6,956,934		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:

06/01/11

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			313,456	313,456	13,447	326,903		326,903			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			842,277	842,277	118,879	961,156	(853,586)	107,570			32
33	Real Estate Taxes			62,591	62,591		62,591		62,591			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			74,369	74,369		74,369		74,369			35
36	Other (specify):*											36
37	TOTAL Ownership			1,292,693	1,292,693	132,326	1,425,019	(853,586)	571,433			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		310,592	1,225	311,817		311,817		311,817			39
40	Barber and Beauty Shops			10,652	10,652		10,652		10,652			40
41	Coffee and Gift Shops	62,424			62,424		62,424		62,424			41
42	Provider Participation Fee			175,686	175,686		175,686		175,686			42
43	Other (specify):* IV Ther/Xray/Lab		53,705	209,463	263,168		263,168		263,168			43
44	TOTAL Special Cost Centers	62,424	364,297	397,026	823,747		823,747		823,747			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,160,117	989,898	4,386,981	9,536,996		9,536,996	(1,184,882)	8,352,114			45

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

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0049395

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,611)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(455)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(90)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,463)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,869)	21		24
25	Fund Raising, Advertising and Promotional	(136,029)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached 5a	(896,365)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,184,882)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,184,882)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heartland of Champaign

ID# 0049395

Report Period Beginning: 06/01/11

Ending: 05/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Wages - Marketing	\$ (31,769)	21	1
2	P/R O/H Alloc - Mktg	(10,450)	21	2
3	HCP Lease Interest	(853,586)	32	3
4	Vending Income	(560)	21	4
5	Misc. Income		21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		36	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		(896,365)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Champaign# 0049395

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	(12,611)	0	0	0	0	0	0	0	0	0	0	(12,611)	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	(12,611)	0	0	0	0	0	0	0	0	0	0	(12,611)	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	(11,463)	0	0	0	0	0	0	0	0	0	0	(11,463)	19
20	Fees, Subscriptions & Promotions	(136,029)	0	0	0	0	0	0	0	0	0	0	(136,029)	20
21	Clerical & General Office Expenses	(171,103)	0	0	0	0	0	0	0	0	0	0	(171,103)	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):*	(90)	0	0	0	0	0	0	0	0	0	0	(90)	27
28	TOTAL General Administration	(318,685)	0	0	0	0	0	0	0	0	0	0	(318,685)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(331,296)	0	0	0	0	0	0	0	0	0	0	(331,296)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Champaign# 0049395

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	(853,586)	0	0	0	0	0	0	0	0	0	0	(853,586)	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	(853,586)	0	0	0	0	0	0	0	0	0	0	(853,586)	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)	(1,184,882)	0	0	0	0	0	0	0	0	0	0	(1,184,882)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	home office
				HL Empl Svcs, LLC	Toledo	personnel
				HL Rehab Svcs, LLC	Toledo	therapy mgmt svcs
				HL Rehab Svcs, LLC	Toledo	therapy services
				HL Home Health Care	Toledo	nursing staff
		See PG6-Supp for list of related nursing homes in Illinois				

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 454,758	HCR Manor Care Services, LLC	100.00%	\$ 454,758	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	4,160,117	Heartland Employment Services, LLC	100.00%	4,160,117		4
5	V	10a Therapy Management	11,587	Heartland Rehabilitation Services, LLC	100.00%	11,587		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		\$ 4,626,462			\$ 4,626,462	\$ *	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:

06/01/11

Ending:

05/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

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0049395

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

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:

06/01/11

Ending: 05/31/12

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 Services, LLC
 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	5	Utilities - Pooled	Accumulated Cost	731 NFs,HHs, 7	\$ 775,999		9,360,915	\$ 1,929	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	353 NFs			9,360,915	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	92 NFs			9,360,915	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			9,360,915	0	4
5	10	Nursing - Pooled	Accumulated Cost	731 NFs,HHs, 7 Reh	485,056	352,684	9,360,915	1,206	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	353 NFs	3,905,972	1,829,606	9,360,915	10,968	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	92 NFs			9,360,915	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			9,360,915	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	731 NFs,HHs, 7 Reh	71,430,003	38,287,220	9,360,915	177,585	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	353 NFs	23,601,055	18,695,747	9,360,915	66,275	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	92 NFs	1,782,698	1,278,408	9,360,915	20,772	11
12	17	Gen/Admin-Direct to MW Div SNFs	Accumulated Cost	48 NFs	895,017	639,204	9,360,915	17,672	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	731 NFs,HHs, 7 Reh	2,952,374		9,360,915	7,340	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	353 NFs	6,653,909		9,360,915	18,685	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	92 NFs			9,360,915	0	15
16	22	Empl Bnfts - Direct to MW Div SNFs	Accumulated Cost	48 NFs			9,360,915	0	16
17	30	Depreciation - Pooled	Accumulated Cost	731 NFs,HHs, 7 Reh	4,719,938		9,360,915	11,734	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	353 NFs	609,966		9,360,915	1,713	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	92 NFs			9,360,915	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	48 NFs			9,360,915	0	20
21									21
22	32	Pooled Interest	Accumulated Cost		26,343,470		9,360,915	65,494	22
23	32	Directly Assigned Interest	Not Allocated		18,851,990			53,385	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions			32,615,916				24
25	TOTALS				\$ 195,623,363	\$ 61,082,869		\$ 454,758	25

Facility Name & ID Number

Heartland of Champaign

0049395

Report Period Beginning:

06/01/11

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Conv Sub Debentures		X	Various			\$ 802,268	\$ 802,268		0.0665	\$ 53,385						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7	Pooled Interest										65,494						
8	Interest Income / Expense										(11,306)						
9	TOTAL Facility Related						\$ 802,268	\$ 802,268			\$ 107,573						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 802,268	\$ 802,268			\$ 107,573						

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.)

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0049395

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>46-21-18-103-011</u>	<u>See Attached</u>	\$ <u>1,832.42</u>	\$ <u>1,832.42</u>
2. <u>46-21-18-103-020</u>	<u>See Attached</u>	\$ <u>2,280.20</u>	\$ <u>2,280.20</u>
3. <u>46-21-18-103-021</u>	<u>See Attached</u>	\$ <u>2,406.14</u>	\$ <u>2,406.14</u>
4. <u>46-21-18-103-005</u>	<u>See Attached</u>	\$ <u>2,468.36</u>	\$ <u>2,468.36</u>
5. <u>46-21-18-103-012</u>	<u>See Attached</u>	\$ <u>3,176.46</u>	\$ <u>3,176.46</u>
6. <u>46-21-18-103-003</u>	<u>See Attached</u>	\$ <u>50,198.00</u>	\$ <u>50,198.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>62,361.58</u></u>	\$ <u><u>62,361.58</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heartland of Champaign

0049395 Report Period Beginning:

06/01/11 Ending:

05/31/12

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:

A. Land.

	1	2	3	4	
	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:

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$	\$ 1,300,178	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Current Year Depreciation				217,285		217,285		2,437,017	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:

06/01/11

Ending:

05/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 EQUP 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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

06/01/11

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XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

06/01/11

Ending:

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XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

06/01/11

Ending:

05/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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	CARPET	2003	1,075						33
34	TOTAL (lines 1 thru 33)		\$ 2,882,610	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

06/01/11

Ending:

05/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 2,882,610	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	1
2	ELEVATORS - OVERHEAD AND INTEREST	2003	3,300						2
3	ELEVATORS CARPENTRY	2003	72,624						3
4	BORDERS	2003	127						4
5	VWC	2003	438						5
6	VWC	2003	4,080						6
7	VWC	2003	571						7
8	CARPET AND INSTALLATION	2003	4,190						8
9	SHOWER ROOM FLOORS AND WALLS	2003	6,901						9
10	SHOWER ROOM FLOORS AND WALLS	2003	289						10
11	DEVELOPERS COSTS - OVERHEAD	2004	17,971						11
12	DEVELOPERS COSTS - INTEREST	2004	1,099						12
13	CARPETING AND PADS	2004	7,249						13
14	WALLCOVERINGS	2004	46,392						14
15	EXTERIOR LIGHT POLE	2004	6,596						15
16	EXTERIOR LIGHT POLE	2004	687						16
17	CONCRETE SLAB	2005	3,115						17
18	VINYL WALL COVERING	2004	1,377						18
19	VINYL WALL COVERING AND PAINTING	2004	9,000						19
20	VINYL WALL COVERING	2004	938						20
21	VINYL WALL COVERING & PAINTING	2004	1,380						21
22	VINYL WALL COVERING & PAINTING	2004	3,420						22
23	COVE BASE	2004	2,160						23
24	DOORS	2004	5,893						24
25	CARPET	2004	4,275						25
26	INSTALL SECURITY DOOR	2005	2,910						26
27	FOURTEEN ARTWORK PIECES	2004	1,117						27
28	ELECTRICAL WORK	2005	5,926						28
29	STAIR TREDS	2005	5,640						29
30	OVERHEAD	2005	13,558						30
31	INTEREST	2005	805						31
32	FLOORING	2005	8,770						32
33	WALL COVERING	2005	8,050						33
34	TOTAL (lines 1 thru 33)		\$ 3,133,458	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

06/01/11

Ending:

05/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 3,133,458	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	1
2	CARPENTRY	2005	1,012						2
3	FENCE	2006	5,140						3
4	FENCE	2006	882						4
5	CERAMIC TILE SHOWER	2006	3,949						5
6	CHAMPAIGN IL	2007	2,550						6
7	SIDEWALK	2008	11,430						7
8	Blgd Im - Arch & Eng Fees	2007	53,414						8
9	Blgd Im - Arch & Eng Fees	2007	205,493						9
10	WALLPAPER	2007	6,605						10
11	CEILING TILES	2007	22,683						11
12	ENGINEERING	2007	17,000						12
13	ROOF REPLACEMENT	2007	66,406						13
14	COMMON AREA FURNISHINGS	2007	316						14
15	COMMON AREA FURNISHINGS	2008	1,605						15
16	CARPET FOR 2ND/3RD FLOOR	2008	26,122						16
17	CARPET FOR 2ND/3RD FLOOR	2008	(1)						17
18	FIRE DAMPERS	2008	75,045						18
19	Renov -(Tot contracted amt) -Painting, Drywall, VWC	2009	10,350						19
20	CARPETING+PADS	2008	9,317						20
21	PAVING/SEALCOATING	2008	5,949						21
22	SEWER LINE	2009	13,911						22
23	Add'l cost Fire Dampers	2008	5,587						23
24	Fire Dampers	2008	50,285						24
25	Kitchen Storage Room Door	2009	5,283						25
26	0310 Renov - General Overhead & Interest	2010	128						26
27	0310 Renov - Carpentry - Subcontr	2010	98,201						27
28	0310 Renov - Carpeting & Pads	2010	12,368						28
29	0310 Renov - Wallcovering & Corner Guards	2010	30,901						29
30	ceramic floors	2010	3,105						30
31	exterior doors	2010	32,279						31
32	0310 Renov - Carpentry - Subcontr additional	2010	178,913						32
33	85- gal water heater	2011	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 4,100,348	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	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:

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Ending:

05/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,100,348	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	1
2	fabric	2011	653						2
3	Frt on Fabric	2011	125						3
4	Wallcovering	2011	1,761						4
5	vinyl fencing	2010	7,875						5
6	Additional cost for vinyl fencing	2010	7,875						6
7	Frt on carpet	2011	1,013						7
8	carpeting	2011	6,910						8
9	2010 Renov - Carpentry - Subcontr - Central Bath	2011	48,222						9
10	Painting	2011	8,123						10
11	FLOORING, WALL TILE, BATHRM RE	2011	14,598						11
12	FLOORING	2011	7,807						12
13	DOOR CLOSURE & CRASH RAIL	2011	3,587						13
14	HP SINGLE DOOR	2011	4,565						14
15	WALLCOVERINGS, FLOORING	2011	36,437						15
16	RENNOR MAKE-UP AIR UNIT	2011	63,180						16
17	ADD'L FLOORING FOR RESIDENT BATHS	2011	2,800						17
18	RECORDS RM UPGRADE	2011	2,655						18
19	NURSE STATION SOFFIT UPGRADE	2011	6,850						19
20	REPLACE EXTERIOR DOORS & FLOORING	2011	14,598						20
21	ELEVATOR RENOVATION	2011	37,209						21
22	ADD'L WALLCOVERING	2011	36,437						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)		\$ 4,413,627	\$ 206,068		\$ 206,068	\$	\$ 3,737,195	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,707,603	\$ 107,388	\$ 107,388	\$		\$ 1,437,313	71
72	Current Year Purchases	47,589						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			13,447	13,447			74
75	TOTALS	\$ 1,755,192	\$ 107,388	\$ 120,835	\$ 13,447		\$ 1,437,313	75

D. Vehicle Costs. (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)	\$ 6,472,805	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 313,456	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 326,903	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,447	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,174,508	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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 42,737 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>31,632</u>	17
18				_____	18
19				_____	19
20				_____	20
21	TOTAL		\$ _____	\$ <u>31,632</u>	21

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

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

Facility Name & ID Number Heartland of Champaign # 0049395 Report Period Beginning: 06/01/11 Ending: 05/31/12
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	3685	hrs	\$ 146,073	(261)	\$ (15,633)	\$ 1,464	3,424	\$ 131,904	1
2	Licensed Speech and Language Development Therapist	10a	3075	hrs	121,908	820	49,224	1,033	3,895	172,165	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	7063	hrs	280,019	4	266	7,134	7,067	287,419	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				310,592		310,592	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): IV Ther/Xray/Lab	43, 2 & 3					209,463	53,705		263,168	13
14	TOTAL				\$ 548,000	563	\$ 243,320	\$ 373,928	14,386	\$ 1,165,248	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

0049395

Report Period Beginning: 06/01/11

Ending:

05/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/12

(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	\$ 1,477	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (422,967))	1,177,973		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)	\$ 1,182,570	\$	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	4,413,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,755,193		16
17	Accumulated Depreciation (book methods)	(5,174,508)		17
18	Deferred Charges	1,905,647		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,203,944	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,386,514	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 122,299	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	323,718		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,165		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Payables	119,111		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 622,293	\$	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)	\$ 1,424,561	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,961,953	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,386,514	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,998,420)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,998,420)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(826,400)	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)	\$ (826,400)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	9,786,773	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 9,786,773	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,961,953	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,801,202	1
2	Discounts and Allowances for all Levels	(3,071,659)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,729,543	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,150,257	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,150,257	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	650	12
13	Barber and Beauty Care	8,113	13
14	Non-Patient Meals	12,611	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	336,470	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	193,815	19
20	Radiology and X-Ray	238,024	20
21	Other Medical Services	38,895	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 828,578	23
D. Non-Operating Revenue			
24	Contributions	2,218	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,218	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)	\$ 8,710,596	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,148,922	31
32	Health Care	3,718,215	32
33	General Administration	2,553,419	33
B. Capital Expense			
34	Ownership	1,292,693	34
C. Ancillary Expense			
35	Special Cost Centers	648,061	35
36	Provider Participation Fee	175,686	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,536,996	40
41	Income before Income Taxes (line 30 minus line 40)**	(826,400)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (826,400)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 552,360	44
45	Private Pay - Net Inpatient Revenue	1,853,750	45
46	Medicare - Net Inpatient Revenue	2,849,702	46
47	Other-(specify) <u>Hospice</u>	1,065	47
48	Other-(specify) <u>Insurance</u>	472,666	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,729,543	49

* 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:

06/01/11

Ending:

05/31/12

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,956	2,170	\$ 73,014	\$ 33.65	1
2	Assistant Director of Nursing	5,715	6,338	175,333	27.66	2
3	Registered Nurses	15,038	16,676	453,663	27.20	3
4	Licensed Practical Nurses	21,658	24,017	501,015	20.86	4
5	CNAs & Orderlies	64,651	71,866	883,892	12.30	5
6	CNA Trainees	124	137	1,493	10.90	6
7	Licensed Therapist	13,823	15,328	607,663	39.64	7
8	Rehab/Therapy Aides	12,579	13,949	353,725	25.36	8
9	Activity Director	4,122	4,579	58,739	12.83	9
10	Activity Assistants					10
11	Social Service Workers	6,454	7,169	134,422	18.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,364	18,168	211,686	11.65	15
16	Dishwashers					16
17	Maintenance Workers	2,471	2,745	55,751	20.31	17
18	Housekeepers	7,971	8,852	106,147	11.99	18
19	Laundry	3,490	3,874	47,117	12.16	19
20	Administrator	2,080	2,080	82,998	39.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,333	13,919	267,232	19.20	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	2,227	2,474	41,584	16.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	4,803	5,333	62,424	11.71	33
34	TOTAL (lines 1 - 33)	197,859	219,674	\$ 4,117,898 *	\$ 18.75	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 7,835	9, 3	36
37	Medical Records Consultant	Monthly 2,453	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			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 73,834	10, 3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 84,122		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heartland of Champaign

0049395

Report Period Beginning: 06/01/11

Ending: 05/31/12

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. ICHS \$3,416
- (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 \$8733
- (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. \$ 35,452 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? YES
If YES, give effective date of lease. 04/07/11
- (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. \$ 175,686
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. \$ 12,611
- (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.