

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0049379</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heartland of Peoria IL, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/10</u> to <u>05/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>5600 N. Glen Elm Dr.</u> <u>Peoria</u> <u>61614</u>			
Number City Zip Code			
County: <u>Peoria</u>			
Telephone Number: <u>(309) 693-8777</u> Fax # <u>(309) 693-8794</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/01/81</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Gary Geise</u>			
Telephone Number: <u>(419) 252-5731</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Barry A. Lazarus</u>	
		(Title) <u>Vice President, Reimbursement</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379 Report Period Beginning: 06/01/10 Ending: 05/31/11

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>144</u>	Skilled (SNF)	<u>144</u>	<u>52,560</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>144</u>	TOTALS	<u>144</u>	<u>52,560</u>	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	<u>12,163</u>	<u>9,689</u>	<u>26,516</u>	<u>48,368</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>12,163</u>	<u>9,689</u>	<u>26,516</u>	<u>48,368</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.02%

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

8 (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 144 and days of care provided 13,825

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name & ID Number Heartland of Peoria IL, LLC # 0049379 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	293,181	29,067	79,395	401,643	8,994	410,637		410,637			1
2	Food Purchase		343,518		343,518		343,518	(3,102)	340,416			2
3	Housekeeping	198,387	31,155	1,751	231,293		231,293		231,293			3
4	Laundry	48,669	43,904	426	92,999		92,999		92,999			4
5	Heat and Other Utilities			180,748	180,748	2,425	183,173		183,173			5
6	Maintenance	84,370	44,187	226,562	355,119		355,119		355,119			6
7	Other (specify):* Medical Waste			806	806		806		806			7
8	TOTAL General Services	624,607	491,831	489,688	1,606,126	11,419	1,617,545	(3,102)	1,614,443			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	3,049,850	277,346	75,350	3,402,546	10,669	3,413,215		3,413,215			10
10a	Therapy	1,293,818	10,454	192,728	1,497,000		1,497,000		1,497,000			10a
11	Activities	112,735	23,510	2,714	138,959		138,959		138,959			11
12	Social Services	175,262		11,698	186,960		186,960		186,960			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,631,665	311,310	299,290	5,242,265	10,669	5,252,934		5,252,934			16
	C. General Administration											
17	Administrative	130,208		555,729	685,937	(172,077)	513,860		513,860			17
18	Directors Fees											18
19	Professional Services			18,885	18,885		18,885	(18,885)				19
20	Dues, Fees, Subscriptions & Promotions			177,378	177,378		177,378	(120,065)	57,313			20
21	Clerical & General Office Expenses	573,661	87,379	67,691	728,731		728,731	(62,445)	666,286			21
22	Employee Benefits & Payroll Taxes			1,017,670	1,017,670	40,975	1,058,645		1,058,645			22
23	Inservice Training & Education			5,325	5,325		5,325		5,325			23
24	Travel and Seminar			10,287	10,287		10,287		10,287			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			411,407	411,407		411,407		411,407			26
27	Other (specify):*											27
28	TOTAL General Administration	703,869	87,379	2,264,372	3,055,620	(131,102)	2,924,518	(201,395)	2,723,123			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,960,141	890,520	3,053,350	9,904,011	(109,014)	9,794,997	(204,497)	9,590,500			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			421,446	421,446	14,207	435,653		435,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			314,038	314,038	94,807	408,845	(316,928)	91,917			32
33	Real Estate Taxes			117,465	117,465		117,465		117,465			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			90,337	90,337		90,337		90,337			35
36	Other (specify):*											36
37	TOTAL Ownership			943,286	943,286	109,014	1,052,300	(316,928)	735,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		506,281	119	506,400		506,400		506,400			39
40	Barber and Beauty Shops			12,474	12,474		12,474		12,474			40
41	Coffee and Gift Shops	81,266			81,266		81,266		81,266			41
42	Provider Participation Fee			78,840	78,840		78,840		78,840			42
43	Other (specify):* IV X-Ray & Lab		20,700	108,105	128,805		128,805		128,805			43
44	TOTAL Special Cost Centers	81,266	526,981	199,538	807,785		807,785		807,785			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,041,407	1,417,501	4,196,174	11,655,082		11,655,082	(521,425)	11,133,657			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,102)	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	(341)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	30,235	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,885)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,029)	21		24
25	Fund Raising, Advertising and Promotional	(120,065)	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	(405,238)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (521,425)		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (521,425)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

ID#0049379

Ending:

06/01/10

05/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Wages - Marketing	\$ (68,213)	21	1
2	Employee benefits - Marketing	(19,106)	21	2
3	HCP Lease Interest	(316,928)	32	3
4	Vending Income	(991)	21	4
5	Misc. Income	0	21	5
6	Activity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	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
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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	(405,238)		49

Summary A

05/31/11

[illegible]

Summary B

05/31/11

[illegible]

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 Svcs	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	\$ 555,729	HCR Manor Care Services, LLC	100.00%	\$ 555,729	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,041,407	Heartland Employment Services, LLC	100.00%	6,041,407		4
5	V	10a	Therapy Management	9,497	Heartland Rehabilitation Services, LLC	100.00%	9,497		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			\$ 6,606,633			\$ 6,606,633	\$ *	14

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

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 Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland-Riverview of East Peoria IL (SNF), L	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 IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) 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

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
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

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 Peoria IL, LLC # 0049379 Report Period Beginning: 06/01/10 Ending: 05/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	\$ 2,652,139	\$ 1,448,591	9,893,379	\$ 8,994	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	9,893,379	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	9,893,379	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	9,893,379	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	9,893,379	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	9,893,379	2,425	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	9,893,379	9,156	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	9,893,379	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	9,893,379	1,513	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	9,893,379	83,904	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	1,871,124	5,027,701	9,893,379	26,725	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	9,893,379	273,023	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	9,893,379	24,724	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	9,893,379	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	9,893,379	16,251	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	9,893,379	970	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	9,893,379	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	9,893,379	13,237	18
19										19
20	32	Directly Assigned Interest				12,736,052			94,807	20
21		Non Central Division Nursing Home Allocation				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 555,729	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv. Sub Debentures		X	Various			\$ 2,108,942	\$ 2,108,942		4.4955	\$ 94,807	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income Other										(2,890)	8	
9	TOTAL Facility Related						\$ 2,108,942	\$ 2,108,942			\$ 91,917	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,108,942	\$ 2,108,942			\$ 91,917	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	163,262	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.)			\$	175,173	2
3. Under or (over) accrual (line 2 minus line 1).			\$	11,911	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	105,554	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	117,465	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	97,291	8	
		2007	104,645	9	
		2008	111,708	10	
		2009	115,243	11	
		2010	116,811	12	
Line 2: \$175,172 = \$115,243 for full year of 2009 + 59,929 for the 1st half of 2010 paid in May 2011.				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
Line 4: \$105,554 = \$56,882 2nd half 2010 + \$48,672 estimate for Jan-May 2011.				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 Heartland of Peoria IL, LLC COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0049379

CONTACT PERSON REGARDING THIS REPORT Gary Geise

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

33,022

B. General Construction Type:

ExteriorMasonry

FrameSteel

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).

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	Facility		1981, 1998, 2001	\$236,851	1
2			2004	42,897	2
3	TOTALS			\$279,748	3

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

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	104			1963	\$ 834,425	\$ 89,765		\$ 89,765	\$	2,416,887	4	
5	20			1992	1,191,466						5	
6	10			1998	911,507						6	
7	10			2002	913,140						7	
8				2007	365,081						8	
	Improvement Type**											
9	Current Year Depreciation					209,950		209,950		2,621,404	9	
10				1978	65,310						10	
11				1979	23,480						11	
12				1981	63,642						12	
13				1982	10,239						13	
14				1983	6,057						14	
15				1984	9,737						15	
16				1985	9,518						16	
17				1987	65,867						17	
18	RETIREMENTS			1987	(33,597)						18	
19				1988	15,166						19	
20				1989	176,034						20	
21				1990	35,994						21	
22				1991	125,588						22	
23				1992	134,218						23	
24	RETIREMENTS			1992	(18,859)						24	
25				1993	29,944						25	
26				1994	78,083						26	
27				1995	44,937						27	
28	ELECTRICAL WORK			1995	5,075						28	
29	CARPET			1995	5,237						29	
30	PAINTING			1995	18,789						30	
31	WALL VINYL			1995	7,203						31	
32	CERAMIC TILE & INSTALLATION			1995	2,283						32	
33	BATHROOM RENOVATION			1995	4,388						33	
34	BATHROOM RENOVATION			1995	6,989						34	
35	FIRE ALARMS/SMOKE DETECTORS			1995	689						35	
36	HVAC WORK			1995	500						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 Peoria IL, LLC

0049379

Report Period Beginning:

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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	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 PAVING/REPAIRS	1995	\$ 1,425	\$		\$	\$	\$	37
38 CAPITALIZED LABOR-BATHROOM	1996	7,272						38
39 CR 5/31/99 AUDIT ADJ-CAPITAL LABOR	1996	(7,272)						39
40 ROOF WORK	1996	1,374						40
41 HOLDING TANK/VALVES	1996	1,942						41
42 DOORS	1996	398						42
43 CARPET	1996	13,137						43
44 TILE	1996	2,036						44
45 WALLCOVERINGS	1996	11,574						45
46 INSTALL TWO BOILERS	1996	12,289						46
47 HERITAGE RENOVATIONS	1996	7,965						47
48 ELECTRICAL/LIGHTING	1996	1,611						48
49 INSTALL CABINETS	1996	12,758						49
50 HEATING/AC WORK	1996	3,759						50
51 EXIT DEVICES	1996	1,765						51
52 DOORS/SIGNS	1996	2,802						52
53 LIGHTING	1997	1,572						53
54 CARPET & INSTALLATION	1997	3,230						54
55 SIDING	1997	2,335						55
56 WALLCOVERINGS	1997	6,104						56
57 INSTALL EXHAUST FAN/LIGHT	1997	2,211						57
58 NITEL SX-200 SYSTEM	1997	23,641						58
59 PAGING SYSTEM	1997	5,333						59
60 ROOFTOP A/C	1997	10,968						60
61 CARPET	1997	829						61
62 CEILING WORK	1997	2,385						62
63 ROOF REPAIRS	1997	2,177						63
64 ALLOC FAC. PLAN-HERITAGE	1997	2,758						64
65 CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1997	(2,758)						65
66 ELECTRIC	1997	2,687						66
67 WATER HEATER/WATER LINE	1997	1,166						67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,247,607	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	70

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

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,247,607	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2	<u>FLOORING/CEILING</u>	1998	3,448						2
3	<u>CARPETING</u>	1998	3,020						3
4	<u>PAINTING</u>	1998	3,020						4
5	<u>WALLCOVERINGS</u>	1998	3,020						5
6	<u>INSTALL HANDRAILS</u>	1998	4,875						6
7	<u>INSTALL DOORS/LOCKS</u>	1998	2,820						7
8	<u>CORPORATE OVERHEAD-HERITAGE ADDTN</u>	1998	1,702						8
9	<u>CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN</u>	1998	(1,702)						9
10	<u>FINISH/STUD</u>	1998	45,863						10
11	<u>CR 5/31/03 AUDIT ADJ 2A-RELCASS FINISH/STUD TO BUILI</u>	1998	(45,863)						11
12	<u>SITE/DEMOLITION</u>	1998	86,230						12
13	<u>CR 5/31/03 AUDIT ADJ 2B-SITE/DEMOLITION</u>	1998	(86,230)						13
14	<u>LANDSCAPING</u>	1998	5,310						14
15	<u>ROOFING</u>	1998	53,000						15
16	<u>CR 5/31/03 AUDIT ADJ 2C-ROOFING</u>	1998	(53,000)						16
17	<u>ELECTRICAL</u>	1998	841						17
18	<u>AIR CONDITIONING</u>	1998	5,617						18
19	<u>CARPETING</u>	1998	1,994						19
20	<u>GENERAL CONTRACTOR-HERITAGE ADDTN</u>	1998	2,524						20
21	<u>CR 5/31/03 AUDIT ADJ 2D-CONTRACTOR FEES</u>	1998	(2,524)						21
22	<u>PAINTING/WALLCOVERING</u>	1998	531						22
23	<u>PLUMBING</u>	1998	7,900						23
24	<u>SIGNAGE</u>	1998	11,862						24
25	<u>GAZEBO</u>	1998	1,325						25
26	<u>50 GAL AMTEK</u>	1999	1,699						26
27	<u>AIR CONDITIONING</u>	1999	1,940						27
28	<u>LAND IMPROVEMENTS-ARCADIA REN</u>	1999	6,099						28
29	<u>LAND IMPROVEMENTS-ARCADIA REN</u>	1999	315						29
30	<u>CONCRETE PAD</u>	1999	713						30
31	<u>EXIT DOOR ALARM</u>	1999	547						31
32	<u>RUSKIN PAMPER</u>	1999	896						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,315,399	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

Facility Name & ID Number Heartland of Peoria IL, LLC

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,315,399	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2	<u>HOT WATER LINE</u>	1999	780						2
3	<u>FURNISHINGS</u>	1999	557						3
4	<u>CR 5/31/03 AUDIT ADJ-FURNISHINGS</u>	1999	(557)						4
5	<u>SMOKING SHELTER</u>	1999	4,950						5
6	<u>BUILDING IMPROVEMENTS-ARCADIA</u>	1999	1,821						6
7	<u>BUILDING IMPROVEMENTS-ARCADIA</u>	1999	780						7
8	<u>LOCKS</u>	1999	4,509						8
9	<u>SMOKING SHELTER</u>	1999	4,950						9
10	<u>RETENTION</u>	1999	29,415						10
11	<u>CR 5/31/03 AUDIT ADJ 3A-RETENTION</u>	1999	(29,415)						11
12	<u>CAMERA SECURITY</u>	1999	3,469						12
13	<u>DOOR</u>	1999	1,011						13
14	<u>FLOOR</u>	1999	774						14
15	<u>ENGINEER/DESIGNER FEES-ARCADIA RENOV</u>	1999	693						15
16	<u>ELECTRICAL CONTRACT-ARCADIA RENOV</u>	1999	450						16
17	<u>PIPING</u>	1999	2,730						17
18	<u>HVAC</u>	1999	1,034						18
19	<u>SECURITY SYSTEM-SECOND HALF</u>	2000	3,468						19
20	<u>FLOOR TILE-RESIDENT ROOM</u>	2000	3,870						20
21	<u>POWERS VALVE</u>	2000	670						21
22	<u>SECURE CARE</u>	2000	1,019						22
23	<u>CR 5/31/03 AUDIT ADJ 3C-RECLASS FROM 2001</u>	2000	40,091						23
24	<u>CR 5/31/03 AUDIT ADJ 3D-RECLASS FROM 2001</u>	2000	29,375						24
25	<u>CR 5/31/03 AUDIT ADJ 3F-RECLASS FROM 2001</u>	2000	14,674						25
26	<u>A/C DUCTLESS SYSTEM</u>	2001	3,774						26
27	<u>VCT - DINING ROOM</u>	2001	4,168						27
28	<u>PAINTING / RETAINAGE</u>	2001	98						28
29	<u>PAINTING</u>	2001	882						29
30	<u>PAINTING</u>	2001	1,000						30
31	<u>GENERAL OVERHEAD-MEDICARE RENOV</u>	2001	57,004						31
32	<u>CR 5/31/03 AUDIT ADJ 3B-GENERAL OVERHEAD</u>	2001	(57,004)						32
33	<u>DRAPES,SHADES,BLINDS</u>	2001	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 5,457,101	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,457,101	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2	CEILING,KICKERBOARD-MEDICARE RENOV	2001	31,746						2
3	CARPET,PAINT,WALLPAPER-MEDICARE RENOV	2001	59,734						3
4	CR 5/31/03 AUDIT ADJ 3C-MEDICARE RENOV	2001	(485)						4
5	CR 5/31/03 AUDIT ADJ 3C-RECLASS TO 2000	2001	(40,091)						5
6	HVAC AND ELECTRICAL	2001	7,683						6
7	PAINT, WALLPAPER	2001	3,470						7
8	DRYWALL,DOOR,CARPENTRY-ARCADIA RENOV	2001	34,121						8
9	WALLPAPER,CARPET-ARCADIA RENOV	2001	58,729						9
10	CR 5/31/03 AUDIT ADJ 3D-ARCADIA RENOV	2001	(4,989)						10
11	CR 5/31/03 AUDIT ADJ 3D-RECLASS TO 2000	2001	(29,375)						11
12	PAINTING-ARCADIA RENOV	2001	12,554						12
13	PLUMBING,ELECTRICAL-ARCADIA RENOV	2001	107,746						13
14	GENERAL OVERHEAD-ARCADIA RENOV	2001	150,192						14
15	CR 5/31/03 AUDIT ADJ 3E-ARCADIA RENOV	2001	(150,192)						15
16	DRAPES,ARTWORK-ARCADIA RENOV	2001	21,753						16
17	CR 5/31/03 AUDIT ADJ 3F-ARCADIA RENOV	2001	(844)						17
18	CR 5/31/03 AUDIT ADJ 3F- RECLASS TO EQUIPMENT	2001	(6,235)						18
19	CR 5/31/03 AUDIT ADJ 3F-RECLASS TO 2000	2001	(14,674)						19
20	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	9,000						20
21	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	4,250						21
22	FLOORING	2001	18,030						22
23	FLOORING	2001	1,052						23
24	CARPET,VINYL WALL COVERING	2001	11,143						24
25	ROOF	2001	184,141						25
26	CR 5/31/03 AUDIT ADJ 4B-OVERHEAD	2001	(1,800)						26
27	CR 5/31/03 AUDIT ADJ 4B-INTEREST	2001	(345)						27
28	SOIL/CONCRETE TEST, FEES	2001	15,756						28
29	GC - SITE WORK	2001	269,327						29
30	CR 5/31/03 AUDIT ADJ 4C- RECLASS TO BUILDING	2001	(239,457)						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,969,041	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

Report Period Beginning:

06/01/10

Ending:

05/31/11

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

1	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		\$ 5,969,041	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2 VWC,FLOORING	2002	8,790						2
3 CABINETS	2002	9,529						3
4 ADDTL CONSTRUCTION COST	2002	117						4
5 CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(117)						5
6 ADDTL CONSTRUCTION COST	2002	560						6
7 CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(560)						7
8 ADDTL CONSTRUCTION COST	2002	109						8
9 WINDOW TREATMENTS	2002	7,067						9
10 ROOFING	2002	1,486						10
11 ADDTL COSTS OF ARCADIA RE	2002	1,274						11
12 ADDTL COSTS OF ARCADIA RE	2002	2,867						12
13 VCT FLOORING	2002	1,484						13
14 VCT FLOORING	2002	1,367						14
15 VCT FLOORING	2002	1,192						15
16 RETAINAGE ON NEW CONSTRUCTION	2002	5,000						16
17 CR 5/31/03 AUDIT ADJ 5B-RETAINAGE	2002	(5,000)						17
18 VWC,FLOORING	2002	1,182						18
19 VWC	2003	133						19
20 FLOORING / WALLCOVERING	2003	95,423						20
21 VWC	2003	685						21
22 FREIGHT ON VWC	2003	433						22
23 KITCHEN DOOR	2003	2,874						23
24 VCT FLOORING	2003	1,109						24
25 VWC & PAINTING	2004	3,500						25
26 AWNING	2004	2,950						26
27 FENCED IN COURTYARD	2005	10,500						27
28 INSTALL GUTTER	2005	5,800						28
29 VINYL WALL COVERING	2004	220						29
30 VINYL WALL COVERING	2004	297						30
31 VINYL WALL COVERING	2004	240						31
32 VINYL WALL COVERING	2004	206						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,129,758	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

Report Period Beginning:

06/01/10

Ending:

05/31/11

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		\$ 6,129,758	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2	VINYL WALL COVERING	2004	362						2
3	VINYL WALL COVERING	2004	1,004						3
4	INSTALL CABINETS	2004	10,272						4
5	PAINTING AND WALLCOVERING	2004	7,200						5
6	VINYL WALL COVERING	2004	1,593						6
7	VINYL TILE AND VINYL WALL COVERING	2004	10,000						7
8	VINYL TILE AND VINYL WALL COVERING	2004	274						8
9	PAINTING AND WALLCOVERING	2005	800						9
10	VINYL WALL COVERING	2004	1,004						10
11	LABOR, PERMITS FOR REHAB ROOM RENOV	2004	2,650						11
12	PAINT DOORS, FRAMES, HEATERS	2004	5,800						12
13	NORSTAR PHONE SYSTEM	2005	18,681						13
14	CUSTOM CABINETS	2005	11,770						14
15	ARCH & ENGINEERING COST	2005	665						15
16	ARCH & ENGINEERING COST	2005	456						16
17	ARCH & ENGINEERING COST	2005	3,585						17
18	CARPET	2005	5,524						18
19	PLUMBING FOR KITCHEN	2004	2,440						19
20	ELECTRICAL FOR KITCHEN	2004	1,975						20
21	FIRE DOOR	2005	4,706						21
22	CARPET	2005	3,060						22
23	CARPET	2005	1,087						23
24	WATER LINES	2005	27,419						24
25	PLUMBING	2005	3,047						25
26	ARCHITECTURAL DRAWINGS	2005	5,623						26
27	WALLCOVERING	2005	1,337						27
28	FIVE HOLLOW METAL DOORS/FRAMES	2006	8,370						28
29	HOLLOW METAL DOOR	2006	1,431						29
30	CARPETING/WALLCOVERING	2006	9,473						30
31	CARPENTRY FOR HALL/OFFICE/LOBBY REN	2006	85,850						31
32	ELECTRICAL FOR FIRE ALARM	2006	3,472						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,370,688	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

Facility Name & ID Number Heartland of Peoria IL, LLC

0049379

Report Period Beginning:

06/01/10

Ending:

05/31/11

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		\$ 6,370,688	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2	FRAME, DRYWALL	2006	3,900						2
3	OVERHEAD & INTEREST	2006	6,737						3
4	FIRE SPRINKLER SYSTEM	2006	124,976						4
5	VINYL TILE	2006	6,500						5
6	CARPET FOR AC CORRIDOR	2006	6,878						6
7	GENERATOR-ENGINEER COSTS, OH & INT	2006	32,929						7
8	GENERATOR-PLAN REVIEWS	2006	2,400						8
9	GENERATOR-ELECTRICAL	2006	209,851						9
10	PT ADDITION-ARCHITECT & ENGINEER COSTS	2007	48,702						10
11	PT ADDITION-GENERAL OVERHEAD	2007	44,998						11
12	PT ADDITION-PLAN REVIEWS	2007	5,553						12
13	PT ADDITION-INTEREST	2007	4,210						13
14	CARPETING, WALL COVERING	2007	5,559						14
15	FIRE SPRINKLER SYSTEM	2007	4,000						15
16	SITE PREP, CONCRETE	2007	19,735						16
17	CONCRETE TESTING	2007	4,395						17
18	LEGAL FEES-SITE PREP	2007	17,853						18
19	1107 SIDEWALK FROM BASEME	2007	44,050						19
20	PRCH PR ADJ 402 013-06C - PARKING (#21)	2007	(1,890)						20
21	1306 PARKING	2007	1,890						21
22	1306 PARKING	2008	170,319						22
23	CARPENTRY IN BASEMENT	2007	4,410						23
24	5 DOORS	2007	4,143						24
25	wallcovering	2007	2,740						25
26	DOORS FOR FIRE DAMPERS	2007	1,387						26
27	CARPET 316, 318, 320, 329	2007	2,046						27
28	WALLPAPER IN MAIN DINING	2007	3,915						28
29	000000003625 FLOORING	2007	5,756						29
30	0207 EMERGENCY EGRESS LIG	2007	8,029						30
31	0207 EMERGENCY EGRESS LIG	2007	66,550						31
32	1107 SIDEWALK FROM BASEME	2007	6,429						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,239,638	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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 12G, Carried Forward		\$ 7,239,638	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	1
2 1306 PARKING	2007	264						2
3 PRCH PR ADJ 402_013-06C PARKING (#2)	2007	(264)						3
4 1306 PARKING	2008	12,681						4
5 00000003649 1306 PARKING (Adjustment to #3638)	2008	1,735						5
6 00000003655 HANDRAILS - HERITAGE WING	2008	11,500						6
7 00000003662 Vinyl Flooring in Patient Rooms	2009	15,226						7
8 00000003663 FRT on Vinyl Flooring	2009	1,070						8
9 00000003665 HERITAGE WING WALL COVER & FLOORIN	2009	20,343						9
10								10
11 Heritage Wing Renovation 015-08C	2009	52,595						11
12 Flooring & lighting	2009	6,750						12
13 Steel Door	2010	2,879						13
14 Guardrail	2010	4,350						14
15 Front Sidewalk	2010	1,789						15
16								16
17 Parking Blocks	2010	7,560						17
18 Seal And Stripe Parking Lot	2010	13,399						18
19 Carpet Squares & Frt. for Carpet	2010	5,212						19
20 3 Door Closures	2010	3,280						20
21 HVAC Unit in activity room	2010	7,315						21
22 Painting & Wallcovering	2011	13,648						22
23 Resident sink	2011	1,665						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)		\$ 7,422,635	\$ 299,715		\$ 299,715	\$	\$ 5,038,291	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	\$1,974,773	\$121,731	\$121,731	\$		\$1,762,875	71
72	Current Year Purchases	214,679						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			14,207	14,207			74
75	TOTALS	\$2,189,452	\$121,731	\$135,938	\$14,207		\$1,762,875	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference				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)			\$	9,891,835
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	421,446
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	435,653
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	14,207
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,801,166

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Various	\$37,210
93		
94		
95		\$37,210

* 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.

YESNO

		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:
- YESNO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$73,400

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		\$	\$16,937	17
18					18
19					19
20					20
21	TOTAL		\$	\$16,937	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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	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, 1	3,039	hrs	\$ 119,683	108,396	\$ 2,346	\$ 4,915	111,435	\$ 126,944	1	
2	Licensed Speech and Language Development Therapist	10a, 1	2,396	hrs	94,367			84	2,396	94,451	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a, 1	8,684	hrs	342,052	45	2,080	5,455	8,729	349,587	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39, 2		# of prescrpts				506,281		506,281	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): IV Therapy	43, 2						20,700		20,700	12	
13	Other (specify): X-Ray & Lab	43, 3					108,105			108,105	13	
14	TOTAL				\$ 556,102	108,441	\$ 112,531	\$ 537,435	122,560	\$ 1,206,068	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.

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	\$ 16,718	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,279)	1,674,147		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,405		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,695,270	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	279,748		13
14	Buildings, at Historical Cost	7,422,635		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,189,452		16
17	Accumulated Depreciation (book methods)	(6,801,166)		17
18	Deferred Charges	28,934,962		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): CIP	37,210		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,062,841	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,758,111	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,285	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	653,072		30
31	Accrued Taxes Payable (excluding real estate taxes)	78,706		31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,554		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	46,059		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,096,676	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	33,565,870		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	21		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 33,565,891	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 34,662,567	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (904,456)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,758,111	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,975,624	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,975,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,038,056	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)	\$3,038,056	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(5,918,136)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$(5,918,136)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$(904,456)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,611,412	1
2	Discounts and Allowances for all Levels	(4,202,801)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,408,611	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,601,469	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,601,469	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	991	12
13	Barber and Beauty Care	12,285	13
14	Non-Patient Meals	3,102	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	529,908	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,708	19
20	Radiology and X-Ray	10,586	20
21	Other Medical Services	72,478	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 683,058	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts		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)	\$ 14,693,138	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,606,126	31
32	Health Care	5,242,265	32
33	General Administration	3,055,620	33
	B. Capital Expense		
34	Ownership	943,286	34
	C. Ancillary Expense		
35	Special Cost Centers	728,945	35
36	Provider Participation Fee	78,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,655,082	40
41	Income before Income Taxes (line 30 minus line 40)**	3,038,056	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,038,056	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.

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	1,582	1,726	\$ 74,564	\$ 43.20	1
2	Assistant Director of Nursing	15,402	16,806	492,834	29.32	2
3	Registered Nurses	7,310	7,976	228,326	28.63	3
4	Licensed Practical Nurses	41,601	45,391	972,712	21.43	4
5	CNAs & Orderlies	100,955	110,473	1,245,560	11.27	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	14,120	15,410	606,941	39.39	7
8	Rehab/Therapy Aides	24,606	26,855	686,877	25.58	8
9	Activity Director	7,489	8,178	112,735	13.79	9
10	Activity Assistants					10
11	Social Service Workers	7,611	8,311	175,262	21.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,622	27,991	293,181	10.47	15
16	Dishwashers					16
17	Maintenance Workers	4,787	5,226	84,370	16.14	17
18	Housekeepers	17,439	19,052	198,387	10.41	18
19	Laundry	5,206	5,686	48,669	8.56	19
20	Administrator	2,080	2,080	86,236	41.46	20
21	Assistant Administrator	1,651	1,651	43,972	26.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,045	25,272	486,342	19.24	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	2,141	2,339	35,854	15.33	31
32	Other Health Care(specify)					32
33	Other(specify)	7,156	7,818	81,266	10.39	33
34	TOTAL (lines 1 - 33)	309,803	338,241	\$ 5,954,088 *	\$ 17.60	34

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	16,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	181	9,104	10, 1	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)	181	\$ 25,904		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides			10, 3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number		Heartland of Peoria IL, LLC		STATE OF ILLINOIS		Page 21		
				# 0049379		Report Period Beginning: 06/01/10		
						Ending: 05/31/11		
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	
Carol Williams	Administrator	0	\$ 86,236	Workers' Compensation Insurance	\$ 79,027	IDPH License Fee	\$ 1,990	
Dana Wikstorm (Dec. '10 - May'11)	Asst. Admin.	0	27,527	Unemployment Compensation Insurance	80,859	Advertising: Employee Recruitment	18,669	
Rechbecca Newable (Jun. '10- Ost. '10)	Asst. Admin.	0	16,445	FICA Taxes	424,827	Health Care Worker Background Check	8,218	
				Employee Health Insurance	389,637	(Indicate # of checks performed 547)		
				Employee Meals		Patient Background Checks	595	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,471	
				Disability Payments		Association Dues	14,584	
				401K	34,442	Advertising	110,487	
TOTAL (agree to Schedule V, line 17, col. 1)				Appreciation, Other Benefits & Marketing Adjust	(7,555)	Other Licenses & Permits	2,009	
(List each licensed administrator separately.)			\$ 130,208	Tuition Program	3,715	Less Non-allowable Association Dues	(9,578)	
B. Administrative - Other				SMSP Match & RSU	35	Less: Public Relations Expense	()	
Description			Amount	Employee Uniforms	12,683	Non-allowable advertising	(110,487)	
Various home offices services			\$ 555,729	Home Office Allocation	40,975	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 555,729	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,058,645	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Elvidge Kelley Attorney at Law	Legal Fees		\$ 1,425				Out-of-State Travel	\$
Michael T. Mahoney, LTD	Legal Fees		16,959					
United Collection Bureau Inc.	Collection Services		501				In-State Travel	10,287
							Includes travel expense to the Home Office in Toledo, OH for regional meetings	
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)								
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,885				TOTAL	\$ 10,287
				* Attach copy of IMRF notifications		**See instructions.		

* Attach copy of IMRF notifications

**See instructions.

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 \$5006
- (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.

\$ 84,419

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.

\$ 78,840

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.

\$ 3,102
- (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 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.