

		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: 0049486

Facility Name: Heartland-Riverview of East Peoria IL (SNF), LLC

Address: 500 Centennial Dr. East Peoria 61611
Number City Zip Code

County: Tazewell

Telephone Number: (309) 694-9865 Fax # (309) 699-2192

HFS ID Number:

Date of Initial License for Current Owners: 10/03/95

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Gary Geise Telephone Number: (419) 252-5731
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/10 to 05/31/11 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.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

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-Riverview of East Peoria IL (SNF), LLC

0049486 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>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</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>71</u>	TOTALS	<u>71</u>	<u>25,915</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>0</u>	<u>5,707</u>	<u>17,034</u>	<u>22,741</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>5,707</u>	<u>17,034</u>	<u>22,741</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.75%

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 10/03/95

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 71 and days of care provided 11,475

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.

STATE OF ILLINOIS

Facility Name & ID NumberHeartland-Riverview of East Peoria IL (SNF)#0049486Report Period Beginning:06/01/10Ending:05/31/11

Page 3

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	210,375			210,375	5,785	216,160		216,160			1
2	Food Purchase		133,229		133,229		133,229	(1,894)	131,335			2
3	Housekeeping	74,950	14,392	1,230	90,572		90,572		90,572			3
4	Laundry	34,807	11,374	944	47,125		47,125		47,125			4
5	Heat and Other Utilities			141,302	141,302	1,560	142,862		142,862			5
6	Maintenance	20,087	14,236	124,230	158,553		158,553		158,553			6
7	Other (specify):* Medical Waste			224	224		224		224			7
8	TOTAL General Services	340,219	173,231	267,930	781,380	7,345	788,725	(1,894)	786,831			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,770,194	197,196	78,001	2,045,391	6,862	2,052,253		2,052,253			10
10a	Therapy	1,089,714	14,415	29,250	1,133,379		1,133,379		1,133,379			10a
11	Activities	44,876	1,999	520	47,395		47,395		47,395			11
12	Social Services	107,675	190		107,865		107,865		107,865			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,012,459	213,800	113,771	3,340,030	6,862	3,346,892		3,346,892			16
	C. General Administration											
17	Administrative	96,006		296,450	392,456	(49,698)	342,758		342,758			17
18	Directors Fees											18
19	Professional Services			8,217	8,217		8,217	(8,217)				19
20	Dues, Fees, Subscriptions & Promotions			43,851	43,851		43,851	(18,117)	25,734			20
21	Clerical & General Office Expenses	284,388	36,996	151,855	473,239		473,239	(187,045)	286,194			21
22	Employee Benefits & Payroll Taxes			640,510	640,510	26,354	666,864		666,864			22
23	Inservice Training & Education			4,090	4,090		4,090		4,090			23
24	Travel and Seminar			6,701	6,701		6,701		6,701			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			209,000	209,000		209,000		209,000			26
27	Other (specify):*											27
28	TOTAL General Administration	380,394	36,996	1,360,674	1,778,064	(23,344)	1,754,720	(213,379)	1,541,341			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,733,072	424,027	1,742,375	5,899,474	(9,137)	5,890,337	(215,273)	5,675,064			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			294,173	294,173	9,137	303,310		303,310			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,089	33,089		33,089	(33,089)				32
33	Real Estate Taxes			74,389	74,389		74,389		74,389			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			75,151	75,151		75,151		75,151			35
36	Other (specify):*											36
37	TOTAL Ownership			476,802	476,802	9,137	485,939	(33,089)	452,850			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,924	2,924		2,924		2,924			38
39	Ancillary Service Centers		401,403		401,403		401,403		401,403			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	51,700			51,700		51,700		51,700			41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* IV X-Ray & Lab		37,522	55,407	92,929		92,929		92,929			43
44	TOTAL Special Cost Centers	51,700	438,925	97,204	587,829		587,829		587,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,784,772	862,952	2,316,381	6,964,105		6,964,105	(248,362)	6,715,743			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	(1,894)	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	(166)	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				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,217)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,843)	21		24
25	Fund Raising, Advertising and Promotional	(18,117)	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	(122,125)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (248,362)		\$	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))	\$ (248,362)		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: Ending:

ID#004948606/01/1005/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Wages - Marketing	\$ (68,213)	21	1
2	Employee benefits - Marketing	(20,823)	21	2
3	HCP Lease Interest	(33,089)	32	3
4	Vending Income	0	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
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	(122,125)		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	\$ 296,450	HCR Manor Care Services, LLC	100.00%	\$ 296,450	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,784,772	Heartland Employment Services, LLC	100.00%	3,784,772		4
5	V	10a	Therapy Management	8,845	Heartland Rehabilitation Services, LLC	100.00%	8,845		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			\$ 4,090,067			\$ 4,090,067	\$ *	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 of Peoria IL, LLC	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-Riverview of East Peoria IL (SNF), LLC # 0049486 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	6,363,111	\$ 5,785	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	6,363,111	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	6,363,111	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	6,363,111	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	6,363,111	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	6,363,111	1,560	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	6,363,111	5,889	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	6,363,111	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	6,363,111	973	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	6,363,111	53,964	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	1,871,124	5,027,701	6,363,111	17,189	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	6,363,111	175,599	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	6,363,111	15,902	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	6,363,111	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	6,363,111	10,452	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	6,363,111	624	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	6,363,111	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	6,363,111	8,513	18
19										19
20	32	Directly Assigned Interest				12,736,052			0	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		\$ 296,450	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	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.)

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.				\$	65,721 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.)				\$	72,646 2
3. Under or (over) accrual (line 2 minus line 1).				\$	6,925 3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	67,464 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.				\$	74,389 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	66,198	8	
		2007	65,125	9	
		2008	69,804	10	
		2009	71,696	11	
		2010	73,597	12	
Line 2: \$72,646 = \$35,848 for the 1st half of 2009 paid in Aug. 2010 + 36,798 for the 1st half of 2010 paid in May 2011.					
Line 4: \$67,464 = \$36,798 2nd half 2010 + \$30,666 estimate for Jan-May 2011.					

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland-Riverview of East Peoria IL (SNF), LLC COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0049486

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 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.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>04-04-25-100-013</u>	<u>See Attached</u>	\$ <u>18,998.78</u>	\$ <u>3,039.80</u>
2.	<u>01-01-23-200-025</u>	<u>See Attached</u>	\$ <u>440,980.28</u>	\$ <u>70,556.84</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u>Real estate tax bills are split between two business units within the building.</u>		\$ <u></u>	\$ <u></u>
5.	<u>16% to Heartland of Riverview SNF. Column (D).</u>		\$ <u></u>	\$ <u></u>
6.	<u>84% to Riverview Senior Living Community</u>		\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u>459,979.06</u>	\$ <u>73,596.64</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? X YES 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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:

22,083

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		1995	\$ 335,515	1
2					2
3	TOTALS			\$ 335,515	3

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	59			1995	\$ 2,170,148	\$ 86,800		\$ 86,800		\$ 599,903
5	CR 5/31/99 Audit Adj			2002	(802,552)					
6	2 (2003) & 6 (2005)			2003	871,303					
7	7/1/06 CAPITAL RATE ADJ #1			2005	29,379					
8	4			2008	707,879					
	Improvement Type**									
9	Current Year Depreciation					135,895		135,895		1,123,457
10	CR 5/31/99 AUDIT ADJ			1990	2,279					
11	CR 5/31/99 AUDIT ADJ			1993	10,497					
12	CR 5/31/99 AUDIT ADJ			1994	975					
13	CR 5/31/99 AUDIT ADJ			1994	3,509					
14	CR 5/31/99 AUDIT ADJ			1995	3,969					
15	FLOORING/CARPETING			1997	2,228					
16	ELECTRICAL			1997	4,089					
17	KICKPLATES			1997	2,838					
18	HOT WATER TANK			1997	2,744					
19	FLOORING			1997	1,825					
20	MOTOR			1997	2,305					
21	GAZEBO IMPROVEMENTS			1997	1,737					
22	WALL COVERING			1997	5,337					
23	ROOM UPGRADES			1997	37,321					
24	SIGNS			1997	1,179					
25	STEAMER			1997	2,587					
26	ROOFING			1998	1,117					
27	FLOORING			1998	4,963					
28	CARPENTRY			1998	3,150					
29	PLUMBING			1998	10,659					
30	WALLCOVERING			1998	9,932					
31	DOOR/WINDOW			1998	658					
32	RENOVATION-PATIENT ROOMS			1998	41,798					
33	FINISH /STUD			1998	4,351					
34	CARPENTRY			1998	4,953					
35	DOOR/WINDOW			1998	14,573					
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

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 FLOORING	1998	\$ 6,859	\$		\$	\$	\$	37
38 PLUMBING	1998	757						38
39 ELECTRICAL	1998	7,844						39
40 PAINTING/WALLCOVERING	1998	12,790						40
41 PAINTING/WALLCOVERING	1998	11,007						41
42 ROOFING	1998	500						42
43 SIGNAGE	1998	28,202						43
44 HVAC	1998	4,530						44
45 CONCRETE SIDEWALK	1998	1,800						45
46 PAINTING/WALLCOVERING	1999	460						46
47 DINING ROOM REMODEL	1999	3,196						47
48 WALLCOVERING	2000	47						48
49 WALLCOVERING	2000	148						49
50 WALLCOVERING	2000	417						50
51 DOUBLE EGRESS DOORS	2000	2,985						51
52 JOCKEY PUMP FOR SPRINKER SYSTEM	2000	310						52
53 OFFICE REMODELING	2000	660						53
54 DINING RENOVATIONS	2000	2,169						54
55 OFFICE RENO	2000	3,064						55
56 CIRCULATING PUMP & PIPING	2000	2,814						56
57 DINING ROOM REMODELING COST	2000	540						57
58 WALLCOVERING	2000	1,689						58
59 PIPING	2000	998						59
60 PIPING COST	2000	22						60
61 ADDTL PIPING COST	2000	274						61
62 PIPING COST	2000	2,475						62
63 PIPING	2000	33,529						63
64 ADDTL COST OFFICE RENOVATION	2000	231						64
65 COUNTERTOP-OFFICE RENOVATION	2000	795						65
66 SPRINKLER WORK	2000	963						66
67 SPRINKLER WORK - RETAINAGE	2000	107						67
68 WALLCOVERING-BUSINESS OFFICES	2000	2,000						68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,291,912	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	70

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,291,912	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	1
2	BORDER - DON OFFICE	2000	30						2
3	WALLCOVERING	2000	95						3
4	CONSULTANT-DINING RM	2000	3,513						4
5	FLOORING-DINING RM	2000	1,091						5
6	FLOORING-DINING RM	2000	70						6
7	WALLCOVERING-DINING RM	2000	573						7
8	DINING RM RENOVATIONS	2000	1,540						8
9	WALLCOVERING	2000	344						9
10	DINING RM DEMO	2000	400						10
11	CONSULTING-OFFICE RENOV	2000	543						11
12	JOHNSON CONTROL COMPRESSOR	2000	1,189						12
13	ELECTRICAL	2000	3,951						13
14	ELECTRICAL-RETAINAGE	2000	439						14
15	PTAC UNITS & DUCKWORK-OFFICE	2000	16,375						15
16	DUCTWORK & WALLS-OFFICES	2000	1,819						16
17	CARPET	2000	4,652						17
18	CARPET	2000	200						18
19	ADDT'L DINING ROOM RENOVATION	2000	161						19
20	ELECTRICAL	2000	1,919						20
21	ELECTRICAL	2000	960						21
22	ADDT'L COSTS OF ROOFTOP	2001	226						22
23	CEILING-TILES LAUNDRY ROOM	2001	1,855						23
24	CEILING TILE	2001	4,985						24
25	TILE CEILING	2001	1,599						25
26	CUSTOM NURSES STATION	2001	8,469						26
27	CEILING TILE	2001	2,350						27
28	VINYL FLOOR COVERING WITH BASE	2001	1,300						28
29	RELOCATE EXHAUST FANS & GRILLE	2001	4,477						29
30	RELOCATE EXHAUST FANS & GRILLE	2001	498						30
31	PAINTING	2001	2,900						31
32	LANDSCAPING	2001	7,097						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,367,532	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	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 12B, Carried Forward		\$ 3,367,532	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	1
2 FIRE CAULKING AND SAFING	2002	3,886						2
3 BORDER	2002	75						3
4 DRYVIT FOR WINDOWS	2002	7,700						4
5 BORDER	2002	101						5
6 WINDOW TREATMENTS	2002	1,670						6
7 WALLCOVERING AND PAINTING	2002	171						7
8 CARPET	2002	3,542						8
9 WALLCOVERING, PAINTING	2002	1,537						9
10 VINYL WALL COVERING	2002	312						10
11 VINYL WALL COVERING	2002	276						11
12 CARPET	2003	298						12
13 VINYL WALL COVERING	2003	2,536						13
14 VINYL WALL COVERING AND BORDER	2003	858						14
15 VINYL WALL COVERING	2003	6,014						15
16 GENERAL CONTRACTING FEES	2003	73,911						16
17 ADDITIONAL COST METAL DOOR	2003	1,087						17
18 VINYL WALL COVERING AND BORDER	2003	10,700						18
19 FLOORING	2003	570						19
20 FREIGHT ON WALL COVERING	2003	105						20
21 FREIGHT ON WALL COVERING	2003	258						21
22 ADDITIONAL CONTRATOR FEES	2003	427						22
23 METAL DOOR	2003	9,782						23
24 ARCHITECT & ENGINEER COSTS	2003	52,481						24
25 GENERAL OVERHEAD	2003	169,901						25
26 7/1/06 CAPITAL RATE ADJ #2	2003	(169,901)						26
27 INTEREST ON CONSTRUCTION	2003	19,685						27
28 7/1/06 CAPITAL RATE ADJ #3	2003	(19,685)						28
29 CARPET AND PAD	2003	11,635						29
30 FREIGHT ON CARPET	2003	64						30
31 7/1/06 CAPITAL RATE ADJ #4	2003	(64)						31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,557,464	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	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 12C, Carried Forward		\$ 3,557,464	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	1
2 FREIGHT ON ARTWORK	2003	244						2
3 7/1/06 CAPITAL RATE ADJ #5	2003	(244)						3
4 FLOORING	2003	10,500						4
5 CONCRETE TESTING	2003	2,407						5
6 GENERAL CONTRACTOR	2003	44,443						6
7 CONCRETE	2003	3,800						7
8 STEEL GUARDRAIL	2004	3,680						8
9 PATIO COVER	2004	13,695						9
10 PATIO COVER - ADDTL COSTS	2004	1,500						10
11 FREIGHT ON VINYL WALL COVERING	2004	255						11
12 PARKING LOT	2005	10,900						12
13 GENERAL CONTRACTOR	2005	29,379						13
14 7/1/06 CAPITAL RATE ADJ #12	2005	(29,379)						14
15 SOIL TESTING	2005	2,262						15
16 CONCRETE TESTING	2005	1,005						16
17 7/1/06 CAPITAL RATE ADJ #13	2005	(1,005)						17
18 SITE PREPARATION	2005	15,633						18
19 AUTOMATIC DOOR CONTROL	2005	2,056						19
20 ARCHITECT & ENGINEER COSTS	2005	60,748						20
21 ARCHITECT & ENGINEER COSTS	2005	8,132						21
22 ENGINEER COSTS - CIVIL	2005	4,200						22
23 ENGINEER COSTS	2005	563						23
24 7/1/06 CAPITAL RATE ADJ #6	2005	(563)						24
25 OVERHEAD	2005	27,918						25
26 7/1/06 CAPITAL RATE ADJ #7	2005	(27,918)						26
27 PERMIT FEES	2005	7,424						27
28 PLAN REVIEWS	2005	2,490						28
29 7/1/06 CAPITAL RATE ADJ #8	2005	(2,490)						29
30 INTEREST	2005	13,848						30
31 7/1/06 CAPITAL RATE ADJ #9	2005	(13,848)						31
32 MILLWORK	2005	2,047						32
33 CARPETING & PADS	2005	985						33
34 TOTAL (lines 1 thru 33)		\$ 3,752,131	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	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 12D, Carried Forward		\$ 3,752,131	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	1
2 WALL COVERING	2005	5,853						2
3 CORNER PADS	2005	369						3
4 OVERHEAD	2005	540						4
5 7/1/06 CAPITAL RATE ADJ #10	2005	(540)						5
6 INTEREST	2005	166						6
7 7/1/06 CAPITAL RATE ADJ #11	2005	(166)						7
8 WALL COVERING	2005	12,298						8
9 CORNER GUARDS	2005	1,092						9
10 CARPENTRY	2005	31,325						10
11 VINYL WALL COVERING	2005	5,530						11
12 0107 OFFIC, LOCKER RM REN	2008	2,955						12
13 0107 OFFIC, LOCKER RM REN	2008	44,873						13
14 0107 OFFIC, LOCKER RM REN	2008	3,240						14
15 ADJ RIVERVIEW2 BUILDING ADDN	2008	(869)						15
16 00000000668 PT, LAND IMP - SITE PREP	2008	149,036						16
17 00000000669 PT, LAND IMP - DEVELOPER FEES	2008	43,606						17
18 00000000656 ALUMINUM ENTRY SYSTEM	2008	20,091						18
19 00000000657 DOOR OPENERS	2008	1,150						19
20 00000000665 0208 CORRIDOR WALL	2008	13,217						20
21 00000000666 PT - BLDIM ARCH & ENG COSTS	2008	110,092						21
22 00000000666 PT - BLDIM DEVELOPER O/H COSTS	2008	339,331						22
23 00000000666 PT - INTEREST	2008	47,691						23
24 00000000667 PT - WALLCOVERING	2008	9,406						24
25 00000000678 0208 CORRIDOR WALL	2008	23,670						25
26								26
27 Replace Concrete	2009	9,950						27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,626,037	\$ 222,695		\$ 222,695	\$	\$ 1,723,360	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	\$1,315,204	\$71,478	\$71,478	\$		\$1,134,420	71
72	Current Year Purchases	85,910						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			9,137	9,137			74
75	TOTALS	\$1,401,114	\$71,478	\$80,615	\$9,137		\$1,134,420	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)	\$6,362,666	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$294,173	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$303,310	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,137	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,857,780	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$46,539
- 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		\$	\$28,612	17
18					18
19					19
20					20
21	TOTAL		\$	\$28,612	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.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	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	4,687	hrs	\$ 178,859	329	\$ 17,176	\$ 938	5,016	\$ 196,973	1
2	Licensed Speech and Language Development Therapist	10a, 1	3,304	hrs	126,094	31	1,593	30	3,335	127,717	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	6,866	hrs	262,017			13,447	6,866	275,464	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				401,403		401,403	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						37,522		37,522	12
13	Other (specify): X-Ray & Lab	43, 3					55,407			55,407	13
14	TOTAL				\$ 566,970	360	\$ 74,176	\$ 453,340	15,217	\$ 1,094,486	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,043	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 295,183)	1,090,327		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,172		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,104,542	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	335,515		13
14	Buildings, at Historical Cost	4,626,039		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,401,112		16
17	Accumulated Depreciation (book methods)	(2,857,780)		17
18	Deferred Charges	131,995		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			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,636,881	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,741,423	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 133,929	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	282,073		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,889		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,464		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	49,822		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 592,177	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,641,288		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)	\$ 2,641,309	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,233,486	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,507,937	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,741,423	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$4,661,564	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$4,661,564	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,543,328	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$2,543,328	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(5,696,955)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$(5,696,955)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$1,507,937	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	\$ 9,546,015	1
2	Discounts and Allowances for all Levels	(3,184,954)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,361,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,599,959	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,599,959	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		12
13	Barber and Beauty Care	3,594	13
14	Non-Patient Meals	1,894	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	428,326	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,811	19
20	Radiology and X-Ray	34,094	20
21	Other Medical Services	34,694	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 546,413	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)	\$ 9,507,433	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	781,380	31
32	Health Care	3,340,030	32
33	General Administration	1,778,064	33
	B. Capital Expense		
34	Ownership	476,802	34
	C. Ancillary Expense		
35	Special Cost Centers	548,956	35
36	Provider Participation Fee	38,873	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,964,105	40
41	Income before Income Taxes (line 30 minus line 40)**	2,543,328	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,543,328	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	2,174	2,380	\$ 71,811	\$ 30.17	1
2	Assistant Director of Nursing	3,399	3,721	102,503	27.55	2
3	Registered Nurses	16,973	18,584	466,551	25.10	3
4	Licensed Practical Nurses	20,435	22,375	492,488	22.01	4
5	CNAs & Orderlies	48,350	53,119	613,961	11.56	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	14,857	16,281	621,312	38.16	7
8	Rehab/Therapy Aides	16,602	18,193	468,402	25.75	8
9	Activity Director	3,723	4,084	44,876	10.99	9
10	Activity Assistants					10
11	Social Service Workers	4,891	5,360	107,675	20.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,481	20,823	210,375	10.10	15
16	Dishwashers					16
17	Maintenance Workers	974	1,067	20,087	18.83	17
18	Housekeepers	6,676	7,325	74,950	10.23	18
19	Laundry	3,393	3,723	34,807	9.35	19
20	Administrator	2,080	2,080	96,006	46.16	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,345	11,496	195,352	16.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,911	2,095	22,880	10.92	31
32	Other Health Care(specify)					32
33	Other(specify)	4,123	4,523	51,700	11.43	33
34	TOTAL (lines 1 - 33)	176,387	197,229	\$ 3,695,736 *	\$ 18.74	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	6,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	119	5,991	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)	119	\$ 11,991		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount	
Candy Moore	Administrator	0	\$ 96,006	Workers' Compensation Insurance		\$ 89,440	IDPH License Fee		\$ 3,980	
				Unemployment Compensation Insurance		44,583	Advertising: Employee Recruitment		6,163	
				FICA Taxes		257,667	Health Care Worker Background Check		5,351	
				Employee Health Insurance		219,750	(Indicate # of checks performed 186)			
				Employee Meals			Patient Background Checks		454	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		2,338	
				Disability Payments		1,821	Association Dues		7,058	
				401K		29,750	Advertising		13,528	
				Appreciation, Other Benefits & Marketing Adjust		(4,723)	Other Licenses & Permits		893	
TOTAL (agree to Schedule V, line 17, col. 1)				Tuition Program		(244)	Less Non-allowable Association Dues		(4,589)	
(List each licensed administrator separately.)			\$ 96,006	SMSP Match & RSU		35	Less: Public Relations Expense		()	
B. Administrative - Other				Employee Uniforms		2,431	Non-allowable advertising		(13,528)	
Description			Amount	Home Office Allocation		26,354	Yellow page advertising		()	
Various home office services			\$ 296,450	TOTAL (agree to Schedule V,		\$ 666,864	TOTAL (agree to Sch. V,		\$ 25,734	
				line 22, col.8)			line 20, col. 8)			
				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**			
				to Owners or Employees			Description		Amount	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 296,450	Description		Line #	Amount	Out-of-State Travel		\$
(Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee			Type	Amount				In-State Travel		6,701
Transworld Collections			Collection Services	\$ 91				Includes travel expense to the Home		
C. Edwin Walker			Legal Fees	291				Office in Toledo, OH for regional meetings		
Littler Mendelson PC			Legal Fees	3,548						
Michael T Mahoney, LTD			Legal Fees	2,441				Seminar Expense		
United Collection Bureau Inc.			Collection Services	1,846						
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)								Entertainment Expense		()
								(agree to Sch. V,		
								line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		TOTAL		\$ 6,701
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,217							

*** 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 \$2469

(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.

\$ 34,113

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.

\$ 38,873

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.

\$ 1,894

(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.