FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049379

Facility Name: Heartland of Peoria IL, LLC

Address: 5600 N. Glen Elm Dr. (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 693-8777 **Fax #** (309) 693-8794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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)
(Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed)
(Date)
(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 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,560	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	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,163	9,689	26,516	48,368	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,163	9,689	26,516	48,368	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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 144 and days of care provided 13,825

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
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.

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
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.

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

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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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

Heartland of Peoria IL, LLC

ID# 0049379

Report Period Beginning: 06/01/10

Ending: 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
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**	(405,238)		49

STATE OF ILLINOIS

Summary A

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

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,102)	0	0	0	0	0	0	0	0	0	0	(3,102)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,102)	0	0	0	0	0	0	0	0	0	0	(3,102)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,885)	0	0	0	0	0	0	0	0	0	0	(18,885)	19
20	Fees, Subscriptions & Promotions	(120,065)	0	0	0	0	0	0	0	0	0	0	(120,065)	20
21	Clerical & General Office Expenses	(62,445)	0	0	0	0	0	0	0	0	0	0	(62,445)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(201,395)	0	0	0	0	0	0	0	0	0	0	(201,395)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(204,497)	0	0	0	0	0	0	0	0	0	0	(204,497)	29

STATE OF ILLINOIS

Summary B

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

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(316,928)	0	0	0	0	0	0	0	0	0	0	(316,928)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(316,928)	0	0	0	0	0	0	0	0	0	0	(316,928)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(521,425)	0	0	0	0	0	0	0	0	0	0	(521,425)	45

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

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

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

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

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

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.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 Divisio	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 Divisio	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 Divisio	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 S	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 Cent	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 S	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	9,893,379	24,724	13
14	22	Employee Benefits - Direct to Cent	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 D	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

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

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

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.

Line 4: $105,554 = $56,882 2nd half 2010 + $48,672 estimate for Jan-May 2011.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-16-451-009	See Attached	$ 205.64	$ 205.64
2.	14-16-451-019	See Attached	$ 878.74	$ 878.74
3.	14-16-451-018	See Attached	$ 794.38	$ 794.38
4.	14-16-451-011	See Attached	$ 1,167.86	$ 1,167.86
5.	14-16-451-008	See Attached	$ 113,764.72	$ 113,764.72
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,811.34	$ 116,811.34

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,022 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 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: 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	WALLVINYL			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: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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: 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 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		$ 5,247,607	$ 299,715		$ 299,715	$	$ 5,038,291	1
2	FLOORING/CEILING	1998	3,448						2
3	CARPETING	1998	3,020						3
4	PAINTING	1998	3,020						4
5	WALLCOVERINGS	1998	3,020						5
6	INSTALL HANDRAILS	1998	4,875						6
7	INSTALL DOORS/LOCKS	1998	2,820						7
8	CORPORATE OVERHEAD-HERITAGE ADDTN	1998	1,702						8
9	CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1998	(1,702)						9
10	FINISH/STUD	1998	45,863						10
11	CR 5/31/03 AUDIT ADJ 2A-RELCASS FINISH/STUD TO BUILI	1998	(45,863)						11
12	SITE/DEMOLITION	1998	86,230						12
13	CR 5/31/03 AUDIT ADJ 2B-SITE/DEMOLITION	1998	(86,230)						13
14	LANDSCAPING	1998	5,310						14
15	ROOFING	1998	53,000						15
16	CR 5/31/03 AUDIT ADJ 2C-ROOFING	1998	(53,000)						16
17	ELECTRICAL	1998	841						17
18	AIR CONDITIONING	1998	5,617						18
19	CARPETING	1998	1,994						19
20	GENERAL CONTRACTOR-HERITAGE ADDTN	1998	2,524						20
21	CR 5/31/03 AUDIT ADJ 2D-CONTRACTOR FEES	1998	(2,524)						21
22	PAINTING/WALLCOVERING	1998	531						22
23	PLUMBING	1998	7,900						23
24	SIGNAGE	1998	11,862						24
25	GAZEBO	1998	1,325						25
26	50 GAL AMTEK	1999	1,699						26
27	AIR CONDITIONING	1999	1,940						27
28	LAND IMPROVEMENTS-ARCADIA REN	1999	6,099						28
29	LAND IMPROVEMENTS-ARCADIA REN	1999	315						29
30	CONCRETE PAD	1999	713						30
31	EXIT DOOR ALARM	1999	547						31
32	RUSKIN PAMPER	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 # 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 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 12B, Carried Forward		$ 5,315,399	$ 299,715		$ 299,715	$	$ 5,038,291	1
2	HOT WATER LINE	1999	780						2
3	FURNISHINGS	1999	557						3
4	CR 5/31/03 AUDIT ADJ-FURNISHINGS	1999	(557)						4
5	SMOKING SHELTER	1999	4,950						5
6	BUILDING IMPROVEMENTS-ARCADIA	1999	1,821						6
7	BUILDING IMPROVEMENTS-ARCADIA	1999	780						7
8	LOCKS	1999	4,509						8
9	SMOKING SHELTER	1999	4,950						9
10	RETENTION	1999	29,415						10
11	CR 5/31/03 AUDIT ADJ 3A-RETENTION	1999	(29,415)						11
12	CAMERA SECURITY	1999	3,469						12
13	DOOR	1999	1,011						13
14	FLOOR	1999	774						14
15	ENGINEER/DESIGNER FEES-ARCADIA RENOV	1999	693						15
16	ELECTRICAL CONTRACT-ARCADIA RENOV	1999	450						16
17	PIPING	1999	2,730						17
18	HVAC	1999	1,034						18
19	SECURITY SYSTEM-SECOND HALF	2000	3,468						19
20	FLOOR TILE-RESIDENT ROOM	2000	3,870						20
21	POWERS VALVE	2000	670						21
22	SECURE CARE	2000	1,019						22
23	CR 5/31/03 AUDIT ADJ 3C-RECLASS FROM 2001	2000	40,091						23
24	CR 5/31/03 AUDIT ADJ 3D-RECLASS FROM 2001	2000	29,375						24
25	CR 5/31/03 AUDIT ADJ 3F-RECLASS FROM 2001	2000	14,674						25
26	A/C DUCTLESS SYSTEM	2001	3,774						26
27	VCT - DINING ROOM	2001	4,168						27
28	PAINTING / RETAINAGE	2001	98						28
29	PAINTING	2001	882						29
30	PAINTING	2001	1,000						30
31	GENERAL OVERHEAD-MEDICARE RENOV	2001	57,004						31
32	CR 5/31/03 AUDIT ADJ 3B-GENERAL OVERHEAD	2001	(57,004)						32
33	DRAPES,SHADES,BLINDS	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: 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 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 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 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 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 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 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 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 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.

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 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 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	000000003649 1306 PARKING (Adjustment to #3638)	2008	1,735						5
6	000000003655 HANDRAILS - HERITAGE WING	2008	11,500						6
7	000000003662 Vinyl Flooring in Patient Rooms	2009	15,226						7
8	000000003663 FRT on Vinyl Flooring	2009	1,070						8
9	000000003665 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.

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

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				$	$	$	$		$	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)	$ 9,891,835	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 421,446	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 435,653	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,207	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,801,166	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various	$ 37,210	92
93			93
94			94
95		$ 37,210	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.

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

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? ☐ YES ☐ NO
   If NO, see instructions.

		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: *

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	$

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: $ 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

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

STATE OF ILLINOIS

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

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

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units		Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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.

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/11 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 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.)

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

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.**

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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.

	Revenue	1 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

	Expenses	2 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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Williams	Administrator	0	$ 86,236
Dana Wikstorm (Dec. '10 - May'11)	Asst. Admin.	0	27,527
Recbecca Newable (Jun. '10- Ost. '10)	Asst. Admin.	0	16,445
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,208

B. Administrative - Other

Description	Amount
Various home offices services	$ 555,729
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 555,729

C. Professional Services

Vendor/Payee	Type	Amount
Elvidge Kelley Attorney at Law	Legal Fees	$ 1,425
Michael T. Mahoney, LTD	Legal Fees	16,959
United Collection Bureau Inc.	Collection Services	501
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,027
Unemployment Compensation Insurance	80,859
FICA Taxes	424,827
Employee Health Insurance	389,637
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	34,442
Appreciation, Other Benefits & Marketing Adjust	(7,555)
Tuition Program	3,715
SMSP Match & RSU	35
Employee Uniforms	12,683
Home Office Allocation	40,975
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,058,645

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	18,669
Health Care Worker Background Check	8,218
(Indicate # of checks performed 547)	
Patient Background Checks 595	5,950
Dues & Subscriptions	15,471
Association Dues	14,584
Advertising	110,487
Other Licenses & Permits	2,009
Less Non-allowable Association Dues	(9,578)
Less: Public Relations Expense	( )
Non-allowable advertising	(110,487)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,313

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,287
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,287

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

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

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 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.