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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049379

Facility Name: Heartland of Peoria

Address: 5600 Glen Elm Drive (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: Jeff Lewandowski **Telephone Number:** (419) 252-5736
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 06/01/14 to 05/31/15 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) Martin Allen
(Title) Director

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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	13,507	4,352	26,894	44,753	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,507	4,352	26,894	44,753	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.15%

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 [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 8,819

Medicare Intermediary Novitas Solutions

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: 5/31

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	173,333	28,103	169,684	371,120		371,120		371,120			1
2	Food Purchase		305,760		305,760		305,760	(574)	305,186			2
3	Housekeeping	171,319	33,356	2,228	206,903		206,903		206,903			3
4	Laundry	39,884	19,117	44,022	103,023		103,023		103,023			4
5	Heat and Other Utilities			204,472	204,472	2,181	206,653		206,653			5
6	Maintenance	80,342	9,409	111,245	200,996		200,996		200,996			6
7	Other (specify):* Med Waste			1,550	1,550		1,550		1,550			7
8	TOTAL General Services	464,878	395,745	533,201	1,393,824	2,181	1,396,005	(574)	1,395,431			8
	B. Health Care and Programs											
9	Medical Director			45,600	45,600		45,600		45,600			9
10	Nursing and Medical Records	3,062,750	241,895	105,351	3,409,996	7,430	3,417,426		3,417,426			10
10a	Therapy	1,297,570	7,016	44,629	1,349,215		1,349,215		1,349,215			10a
11	Activities	108,385	5,134	3,517	117,036		117,036		117,036			11
12	Social Services	181,748	288	8,076	190,112		190,112		190,112			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,650,453	254,333	207,173	5,111,959	7,430	5,119,389		5,119,389			16
	C. General Administration											
17	Administrative	102,190		587,970	690,160	(283,902)	406,258		406,258			17
18	Directors Fees											18
19	Professional Services			23,233	23,233		23,233	(23,233)				19
20	Dues, Fees, Subscriptions & Promotions			108,516	108,516		108,516	(75,651)	32,865			20
21	Clerical & General Office Expenses	543,952	51,243	349,787	944,982		944,982	(277,203)	667,779			21
22	Employee Benefits & Payroll Taxes			956,940	956,940	40,385	997,325		997,325			22
23	Inservice Training & Education			2,733	2,733		2,733		2,733			23
24	Travel and Seminar			19,652	19,652		19,652		19,652			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,685	75,685		75,685		75,685			26
27	Other (specify):*											27
28	TOTAL General Administration	646,142	51,243	2,124,516	2,821,901	(243,517)	2,578,384	(376,087)	2,202,297			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,761,473	701,321	2,864,890	9,327,684	(233,906)	9,093,778	(376,661)	8,717,117			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 #0049379 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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			316,512	316,512	14,421	330,933		330,933			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,064,697	2,064,697	219,485	2,284,182	(2,070,304)	213,878			32
33	Real Estate Taxes			118,675	118,675		118,675		118,675			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,179	57,179		57,179		57,179			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,557,063	2,557,063	233,906	2,790,969	(2,070,304)	720,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		395,187		395,187		395,187		395,187			39
40	Barber and Beauty Shops			4,134	4,134		4,134		4,134			40
41	Coffee and Gift Shops	21,740			21,740		21,740		21,740			41
42	Provider Participation Fee			281,669	281,669		281,669		281,669			42
43	Other (specify):* **IV Therapy**		42,096	64,675	106,771		106,771		106,771			43
44	**TOTAL Special Cost Centers**	21,740	437,283	350,478	809,501		809,501		809,501			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,783,213	1,138,604	5,772,431	12,694,248		12,694,248	(2,446,965)	10,247,283			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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(574)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(95)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(147)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(2,260)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,417)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(273,502)	21		24
25	Fund Raising, Advertising and Promotional	(75,651)	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 Page 5a	(2,075,319)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,446,965)		$	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))**	$ (2,446,965)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heartland of Peoria

ID# 0049379

Report Period Beginning: 06/01/14

Ending: 05/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income	(1,199)	21	3
4	Accouning/Collection Fees	(3,816)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(2,070,304)	32	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**	(2,075,319)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Peoria **#** 0049379 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(574)	0	0	0	0	0	0	0	0	0	0	(574)	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**	(574)	0	0	0	0	0	0	0	0	0	0	(574)	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	(23,233)	0	0	0	0	0	0	0	0	0	0	(23,233)	19
20	Fees, Subscriptions & Promotions	(75,651)	0	0	0	0	0	0	0	0	0	0	(75,651)	20
21	Clerical & General Office Expenses	(277,203)	0	0	0	0	0	0	0	0	0	0	(277,203)	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**	(376,087)	0	0	0	0	0	0	0	0	0	0	(376,087)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(376,661)	0	0	0	0	0	0	0	0	0	0	(376,661)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Peoria # 0049379 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

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	(2,070,304)	0	0	0	0	0	0	0	0	0	0	(2,070,304)	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**	(2,070,304)	0	0	0	0	0	0	0	0	0	0	(2,070,304)	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)**	(2,446,965)	0	0	0	0	0	0	0	0	0	0	(2,446,965)	45

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

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	$ 587,970	HCR Manor Care Services, LLC	100.00%	$ 587,970	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,783,213	Heartland Employment Services, LLC	100.00%	5,783,213		4
5	V	10a	Therapy Management	15,035	Heartland Rehabilitation Services, LLC	100.00%	15,035		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			$ 6,386,218			$ 6,386,218	$ *	14

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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								1
2			Heartland of Canton IL, LLC	Canton				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, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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			Heartland of Champaign IL, LLC	Champaign				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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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 Summitt Street
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	5	Utilities - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, &	$ 700,139	$	12,365,665	$ 2,181	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs			12,365,665	0	2
3	5	Utilities - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			12,365,665	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	365,628	262,581	12,365,665	1,139	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	12,365,665	6,291	5
6	10	Nursing - Direct to Western Div S	Accumulated Cost	346,847,752	45 NFs			12,365,665	0	6
7	17	Gen & Admin - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	68,653,771	35,393,585	12,365,665	213,875	7
8	17	Gen & Admin - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	12,365,665	44,729	8
9	17	Gen & Admin-Direct to MW Div	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275		9,274,249	37,736	9
10	17	Gen & Admin - Direc toW Div SN	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860		3,091,416	7,728	10
11	22	Employee Ben - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	5,418,631		12,365,665	16,881	11
12	22	Employee Ben - Direct to SNFs	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		12,365,665	23,504	12
13	22	Employee Ben - Direct to W Div S	Accumulated Cost	346,847,752	45 NFs			12,365,665	0	13
14	30	Deprec - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & Re	3,871,414		12,365,665	12,061	14
15	30	Deprec - Direct to all SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		12,365,665	2,360	15
16	30	Deprec - Direct to W Div SNFs	Accumulated Cost	346,847,752	45 NFs			12,365,665	0	16
17										17
18										18
19	32	Pooled Interest	Accumulated Cost	3,969,355,509		25,971,677		12,365,665	80,909	19
20	32	Directly Assigned Interest	Not Allocated			17,184,434			138,576	20
21										21
22	24	H/O costs Allocated to non-SNF & Other Divisions				33,870,689				22
23										23
24										24
25	TOTALS					$ 179,754,380	$ 39,285,837		$ 587,970	25

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub Debentures		X				$ 2,108,942	$ 2,108,942		0.0657	$ 138,576	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										80,909	7
8	Interest Expense / Interest Income										(5,607)	8
9	TOTAL Facility Related						$ 2,108,942	$ 2,108,942			$ 213,878	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			$ 213,878	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 # 0049379 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 107,001	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.)		$ 117,416	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,415	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 108,260	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.		$ 118,675	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	116,811	8
	2011	117,567	9
	2012	116,714	10
	2013	116,728	11
	2014	118,103	12

Line 2: $117,415.49 = $58,364.21 for 2nd half 2013 + $59,051.28 for 1st half 2014

Line 4: $108,260.45 = $59,051.28 for 2nd half 2014 + $49,209.17 for Jan - May 2015

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0049379

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-16-451-018	See Attached	$ 749.32	$ 749.32
2.	14-16-451-006	See Attached	$ 192.40	$ 192.40
3.	14-16-451-011	See Attached	$ 1,102.80	$ 1,102.80
4.	14-16-451-019	See Attached	$ 828.48	$ 828.48
5.	14-16-451-008	See Attached	$ 115,229.56	$ 115,229.56
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,102.56	$ 118,102.56

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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, 2	$ 236,851	1
2			2004	42,897	2
3	TOTALS			$ 279,748	3

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	$ 65,820		$ 65,820	$	$ 2,689,903	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 Yerar Depreciation					146,417		146,417		3,230,912	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	97,515						27
28				1996	73,410						28
29				1997	64,638						29
30				1998	55,583						30
31				1999	40,160						31
32				2000	93,167						32
33				2001	532,524						33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	VWC,FLOORING	2002	$ 8,790	$		$	$	$	37
38	CABINETS	2002	9,529						38
39	ADDTL CONSTRUCTION COST	2002	117						39
40	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(117)						40
41	ADDTL CONSTRUCTION COST	2002	560						41
42	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(560)						42
43	ADDTL CONSTRUCTION COST	2002	109						43
44	WINDOW TREATMENTS	2002	7,067						44
45	ROOFING	2002	1,486						45
46	ADDTL COSTS OF ARCADIA RE	2002	1,274						46
47	ADDTL COSTS OF ARCADIA RE	2002	2,867						47
48	VCT FLOORING	2002	1,484						48
49	VCT FLOORING	2002	1,367						49
50	VCT FLOORING	2002	1,192						50
51	RETAINAGE ON NEW CONSTRUCTION	2002	5,000						51
52	CR 5/31/03 AUDIT ADJ 5B-RETAINAGE	2002	(5,000)						52
53	VWC,FLOORING	2002	1,182						53
54	VWC	2003	133						54
55	FLOORING / WALLCOVERING	2003	95,423						55
56	VWC	2003	685						56
57	FREIGHT ON VWC	2003	433						57
58	KITCHEN DOOR	2003	2,874						58
59	VCT FLOORING	2003	1,109						59
60	VWC & PAINTING	2004	3,500						60
61	AWNING	2004	2,950						61
62	FENCED IN COURTYARD	2005	10,500						62
63	INSTALL GUTTER	2005	5,800						63
64	VINYL WALL COVERING	2004	220						64
65	VINYL WALL COVERING	2004	297						65
66	VINYL WALL COVERING	2004	240						66
67	VINYL WALL COVERING	2004	206						67
68	VINYL WALL COVERING	2004	362						68
69	VINYL WALL COVERING	2004	1,004						69
70	TOTAL (lines 4 thru 69)		$ 6,131,124	$ 212,237		$ 212,237	$	$ 5,920,815	70

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 6,131,124	$ 212,237		$ 212,237	$	$ 5,920,815	1
2	INSTALL CABINETS	2004	10,272						2
3	PAINTING AND WALLCOVERING	2004	7,200						3
4	VINYL WALL COVERING	2004	1,593						4
5	VINYL TILE AND VINYL WALL COVERING	2004	10,000						5
6	VINYL TILE AND VINYL WALL COVERING	2004	274						6
7	PAINTING AND WALLCOVERING	2005	800						7
8	VINYL WALL COVERING	2004	1,004						8
9	LABOR, PERMITS FOR REHAB ROOM RENOV	2004	2,650						9
10	PAINT DOORS, FRAMES, HEATERS	2004	5,800						10
11	NORSTAR PHONE SYSTEM	2005	18,681						11
12	CUSTOM CABINETS	2005	11,770						12
13	ARCH & ENGINEERING COST	2005	665						13
14	ARCH & ENGINEERING COST	2005	456						14
15	ARCH & ENGINEERING COST	2005	3,585						15
16	CARPET	2005	5,524						16
17	PLUMBING FOR KITCHEN	2004	2,440						17
18	ELECTRICAL FOR KITCHEN	2004	1,975						18
19	FIRE DOOR	2005	4,706						19
20	CARPET	2005	3,060						20
21	CARPET	2005	1,087						21
22	WATER LINES	2005	27,419						22
23	PLUMBING	2005	3,047						23
24	ARCHITECTURAL DRAWINGS	2005	5,623						24
25	WALLCOVERING	2005	1,337						25
26	FIVE HOLLOW METAL DOORS/FRAMES	2006	8,370						26
27	HOLLOW METAL DOOR	2006	1,431						27
28	CARPETING/WALLCOVERING	2006	9,473						28
29	CARPENTRY FOR HALL/OFFICE/LOBBY REN	2006	85,850						29
30	ELECTRICAL FOR FIRE ALARM	2006	3,472						30
31	FRAME, DRYWALL	2006	3,900						31
32	OVERHEAD & INTEREST	2006	6,737						32
33	FIRE SPRINKLER SYSTEM	2006	124,976						33
34	TOTAL (lines 1 thru 33)		$ 6,506,301	$ 212,237		$ 212,237	$	$ 5,920,815	34

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 6,506,301	$ 212,237		$ 212,237	$	$ 5,920,815	1
2	VINYL TILE	2006	6,500						2
3	CARPET FOR AC CORRIDOR	2006	6,878						3
4	GENERATOR-ENGINEER COSTS, OH & INT	2006	32,929						4
5	GENERATOR-PLAN REVIEWS	2006	2,400						5
6	GENERATOR-ELECTRICAL	2006	209,851						6
7	PT ADDITION-ARCHITECT & ENGINEER COSTS	2007	48,702						7
8	PT ADDITION-GENERAL OVERHEAD	2007	44,998						8
9	PT ADDITION-PLAN REVIEWS	2007	5,553						9
10	PT ADDITION-INTEREST	2007	4,210						10
11	CARPETING, WALL COVERING	2007	5,559						11
12	FIRE SPRINKLER SYSTEM	2007	4,000						12
13	SITE PREP, CONCRETE	2007	19,735						13
14	CONCRETE TESTING	2007	4,395						14
15	LEGAL FEES-SITE PREP	2007	17,853						15
16	1107 SIDEWALK FROM BASEME	2007	44,050						16
17	PRCH PR ADJ 402 013-06C - PARKING (#21)	2007	(1,890)						17
18	1306 PARKING	2007	1,890						18
19	1306 PARKING	2008	170,319						19
20	CARPENTRY IN BASEMENT	2007	4,410						20
21	5 DOORS	2007	4,143						21
22	wallcovering	2007	2,740						22
23	DOORS FOR FIRE DAMPERS	2007	1,387						23
24	CARPET 316, 318, 320, 329	2007	2,046						24
25	WALLPAPER IN MAIN DINING	2007	3,915						25
26	000000003625 FLOORING	2007	5,756						26
27	0207 EMERGENCY EGRESS LIG	2007	8,029						27
28	0207 EMERGENCY EGRESS LIG	2007	66,550						28
29	1107 SIDEWALK FROM BASEME	2007	6,429						29
30	**1306 PARKING**	2007	264						30
31	**PRCH PR ADJ 402 013-06C PARKING (#2)**	2007	(264)						31
32	**1306 PARKING**	2008	12,681						32
33	**000000003649 1306 PARKING (Adjustment to #3638)**	2008	1,735						33
34	TOTAL (lines 1 thru 33)		$ 7,254,054	$ 212,237		$ 212,237	$	$ 5,920,815	34

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 7,254,054	$ 212,237		$ 212,237	$	$ 5,920,815	1
2	000000003655 HANDRAILS - HERITAGE WING	2008	11,500						2
3	000000003662 Vinyl Flooring in Patient Rooms	2009	15,226						3
4	000000003663 FRT on Vinyl Flooring	2009	1,070						4
5	000000003665 HERITAGE WING WALL COVER & FLOORIN(	2009	20,343						5
6									6
7	VWC, paint, rubber base - 18 res. rm, & hall in Heritage Wing	2009	52,595						7
8	Flooring & lighting	2009	6,750						8
9	Steel Door	2010	2,879						9
10	Guardrail	2010	4,350						10
11	Front Sidewalk	2010	1,789						11
12									12
13	Parking Blocks	2010	7,560						13
14	Seal And Stripe Parking Lot	2010	13,399						14
15	Carpet Squares & Frt. for Carpet	2010	5,212						15
16	3 Door Closures	2010	3,280						16
17	HVAC Unit in activity room	2010	7,315						17
18	Repair/Paint exterior walls around 21 resident room P-Tec units	2011	13,648						18
19	Resident sink	2011	1,665						19
20									20
21	Security System at Doors & Hardware	2011	69,960						21
22	Circuit Panel upgrade in Mech Rm	2011	5,265						22
23	Water Heater	2011	15,325						23
24									24
25	Front Doors	2011	6,367						25
26	Plumbing Upgrade for fire system	2012	12,944						26
27	Renovations to lobby, lounge, front nurses station, back nurses station, corridors, front offices, med room, and activities room consisting of:								27
28	Carpentry, Millwork, Handrails, Flooring - Renov. 01-12MW	2012	211,324						28
29	Carpeting, Wallcovering, Corner Guards - Renov. 01-12MW	2012	72,991						29
30	Light Fixtures - Renov. 01-12MW	2012	10,214						30
31	Carpentry, Tile Work, Doors & Frames - Renov. 01-12MW	2013	32,988						31
32	Carpentry, Ceiling, Flooring - Renov. 01-12MW	2013	23,855						32
33	Water Heater, 60 gallon	2013	7,877						33
34	TOTAL (lines 1 thru 33)		$ 7,891,745	$ 212,237		$ 212,237	$	$ 5,920,815	34

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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		$ 7,891,745	$ 212,237		$ 212,237	$	$ 5,920,815	1
2	Springler Plumbing Upgrade	2013	1,438						2
3	Paint, Wallcovering, Lights-Arcadia Corridor, Lounge, Nurse Stat	2013	32,551						3
4	Carpeting in Corridor	2013	5,737						4
5	Fire Alarm mother control board	2013	2,733						5
6	Ceiling Tiles & Grids in Arcadia Corridors	2013	8,165						6
7	Painting, Wallcovering, & Carpet in Corridor	2013	24,621						7
8	Light fixture upgrade - whole building	2014	18,863						8
9	PHONE MODULE	2014	2,641						9
10	SPRINKLER DRY HEADS	2015	1,620						10
11	HVAC compressor	2014	2,863						11
12	GEN ELEC UPGRADES	2014	8,925						12
13	2-100 gal water heaters - kithcen & laundry rooms	2014	17,962						13
14	DOOR UPGRADE	2014	1,026						14
15	painting breakroom	2014	2,565						15
16	ceiling in grand heritage office	2014	1,485						16
17	painting of room 508	2014	1,433						17
18	kitchen drain	2014	4,747						18
19	WALLCOVERING	2014	6,324						19
20	Painting in dining room	2014	7,965						20
21	painting arcadia & A/L Dining	2014	11,580						21
22	painting resident rms 516-17 & 519-20	2014	10,364						22
23	painting resident rms 516-17 & 519-21	2014	26,842						23
24	painting laundry room	2014	4,485						24
25	painting -8 ofcs & lobby/entrance doors. 100-200-300 hall doors. Grand heritage								25
26	and arcadia	2014	15,794						26
27	asphalt repairs in parking lot	2014	8,807						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,123,281	$ 212,237		$ 212,237	$	$ 5,920,815	34

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	$ 2,350,040	$ 104,275	$ 104,275	$		$ 2,161,007	71
72	Current Year Purchases	59,720						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			14,421	14,421			74
75	TOTALS	$ 2,409,760	$ 104,275	$ 118,696	$ 14,421		$ 2,161,007	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)	$ 10,812,789	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 316,512	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 330,933	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,421	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,081,822	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.

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 40,240 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		$	$ 16,939	17
18					18
19					19
20					20
21	TOTAL		$	$ 16,939	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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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.

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	5392 hrs	$ 216,806		$	$ 1,362	5,392	$ 218,168	1
2	Licensed Speech and Language Development Therapist	10a	1850 hrs	74,390			505	1,850	74,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5670 hrs	227,981			5,149	5,670	233,130	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				395,187		395,187	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Ther/IV Therapy	43, 2			855	44,097	42,096	855	86,193	12
13	Other (specify): X-Ray/Lab	43, 3				64,675			64,675	13
14	TOTAL			$ 519,177	855	$ 108,772	$ 444,299	13,767	$ 1,072,248	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/15 (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	$ 6,299	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,718,915))	1,256,073		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,788		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,267,160	$	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	8,123,281		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,409,760		16
17	Accumulated Depreciation (book methods)	(8,081,822)		17
18	Deferred Charges	12,291,069		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe OMIT	20,621		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,042,657	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,309,817	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,271	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	487,990		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,260		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	104,974		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 836,495	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,108,942		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,108,942	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,945,437	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,364,380	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,309,817	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Peoria **#** 0049379 **Report Period Beginning:** 06/01/14 **Ending:** 05/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,759,415	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,759,415	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(506,345)	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)**	$ (506,345)	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	111,310	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 111,310	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 13,364,380	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,384,852	1
2	Discounts and Allowances for all Levels	(5,735,727)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,649,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,470,843	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,470,843	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,199	12
13	Barber and Beauty Care	2,821	13
14	Non-Patient Meals	574	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	839,853	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	98,974	19
20	Radiology and X-Ray	41,245	20
21	Other Medical Services	83,174	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,067,840	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 Discount	95	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 95	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,187,903	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,393,824	31
32	Health Care	5,111,959	32
33	General Administration	2,821,901	33
	B. Capital Expense		
34	Ownership	2,557,063	34
	C. Ancillary Expense		
35	Special Cost Centers	527,832	35
36	Provider Participation Fee	281,669	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,694,248	40
41	**Income before Income Taxes (line 30 minus line 40)****	(506,345)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (506,345)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,408,544	44
45	Private Pay - Net Inpatient Revenue	1,285,928	45
46	Medicare - Net Inpatient Revenue	1,146,678	46
47	Other-(specify) Hospice	485,188	47
48	Other-(specify) Insurance	1,322,787	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,649,125	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	1,800	1,951	$ 89,925	$ 46.09	1
2	Assistant Director of Nursing	11,327	12,279	398,727	32.47	2
3	Registered Nurses	18,196	19,724	569,075	28.85	3
4	Licensed Practical Nurses	33,510	36,324	802,230	22.09	4
5	CNAs & Orderlies	92,744	100,850	1,168,915	11.59	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	15,574	16,889	679,091	40.21	7
8	Rehab/Therapy Aides	21,297	23,095	618,479	26.78	8
9	Activity Director	6,106	6,662	108,385	16.27	9
10	Activity Assistants					10
11	Social Service Workers	7,676	8,328	181,748	21.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,054	15,260	173,333	11.36	15
16	Dishwashers					16
17	Maintenance Workers	3,376	3,666	80,342	21.92	17
18	Housekeepers	14,602	15,840	171,319	10.82	18
19	Laundry	4,010	4,351	39,884	9.17	19
20	Administrator	2,080	2,080	102,190	49.13	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,047	23,872	543,952	22.79	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	1,898	2,061	33,878	16.44	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,918	2,083	21,740	10.44	33
34	TOTAL (lines 1 - 33)	272,215	295,315	$ 5,783,213 *	$ 19.58	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	46,500	9, 3	36
37	Medical Records Consultant	270	13,634	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	$ 60,134		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Williams	Administrator	0	$ 102,190
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,190

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 587,970
TOTAL (agree to Schedule V, line 17, col. 3)	$ 587,970
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Elvidge Kelley Atty @ Law	Legal Fees	$ 14,463
SNF Global	Legal Fees	4,835
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)		
Healthlink Inc	Collection Services	25
Michael T Mahoney LTD	Collection Services	3,247
Transworld Systems Inc	Collection Services	664
(Collection Costs were adjusted off via Page 5a, Line 6)		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 23,233

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,770
Unemployment Compensation Insurance	80,765
FICA Taxes	418,378
Employee Health Insurance	344,526
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	8,088
Oth Empl Benefits & Marketing Adjustment	14,029
Tuition Reimbursement	
SMSP Match	7
Employee Uniforms	4,377
Home Office Allocation	40,385
TOTAL (agree to Schedule V, line 22, col.8)	$ 997,325

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,120
Health Care Worker Background Check	
(Indicate # of checks performed 314)	3,835
Patient Background Checks 593	5,930
Dues & Subscriptions	10,992
Association Dues	8,226
Advertising	72,583
Other Licenses & Permits	1,840
Less: Non-allowable Assn. Dues	(3,068)
Less: Public Relations Expense	( )
Non-allowable advertising	(72,583)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,865

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	19,652
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)	$ 19,652

* Attach copy of IMRF notifications

**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 # 0049379 Report Period Beginning: 06/01/14 Ending: 05/31/15

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. **ICHA $3,106 & AHCA $2,052**

(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. $ **68,146** 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. $ **281,669**
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. $ **574**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NO**
Attach invoices and a summary of services for all architect and appraisal fees.