

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0049379</u></p> <p><b>Facility Name:</b> <u>Heartland of Peoria</u></p> <p><b>Address:</b> <u>5600 Glen Elm Drive</u> <u>Peoria</u> <u>61614</u>  Number City Zip Code</p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> <u>(309) 693-8777</u> <b>Fax #</b> <u>(309) 693-8794</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>11/01/81</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Jeff Lewandowski</u> <b>Telephone Number:</b> <u>(419) 252-5736</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/15</u> to <u>05/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Heartland of Peoria

# 0049379 Report Period Beginning: 06/01/15 Ending: 05/31/16

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,704	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	52,704	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,205	4,962	16,472	40,639	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,205	4,962	16,472	40,639	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.11%**

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

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

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

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

None

**F. Does the facility maintain a daily midnight census?**

Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**

YES  NO

**I. On what date did you start providing long term care at this location?**

Date started 11/01/81

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 04/07/11 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified 144 and days of care provided 5,194

Medicare Intermediary Novitas Solutions

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/15 Ending: 05/31/16

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	272,707	25,184	71,433	369,324		369,324		369,324		1
2	Food Purchase		300,718		300,718		300,718	(15)	300,703		2
3	Housekeeping	195,165	23,814	534	219,513		219,513		219,513		3
4	Laundry	44,289	18,567	34,412	97,268		97,268		97,268		4
5	Heat and Other Utilities			198,550	198,550	2,522	201,072		201,072		5
6	Maintenance	58,681	11,290	84,400	154,371		154,371		154,371		6
7	Other (specify):* <b>Med Waste</b>			563	563		563		563		7
8	<b>TOTAL General Services</b>	570,842	379,573	389,892	1,340,307	2,522	1,342,829	(15)	1,342,814		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			29,475	29,475		29,475		29,475		9
10	Nursing and Medical Records	2,859,497	202,986	45,899	3,108,382	8,466	3,116,848		3,116,848		10
10a	Therapy	1,037,921	6,261	45,463	1,089,645		1,089,645		1,089,645		10a
11	Activities	87,255	7,510	5,146	99,911		99,911		99,911		11
12	Social Services	128,782		7,101	135,883		135,883		135,883		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,113,455	216,757	133,084	4,463,296	8,466	4,471,762		4,471,762		16
	<b>C. General Administration</b>										
17	Administrative	108,003		580,454	688,457	(301,506)	386,951		386,951		17
18	Directors Fees										18
19	Professional Services			40,640	40,640		40,640	(40,640)			19
20	Dues, Fees, Subscriptions & Promotions			78,021	78,021		78,021	(25,258)	52,763		20
21	Clerical & General Office Expenses	527,443	34,571	455,254	1,017,268		1,017,268	(395,491)	621,777		21
22	Employee Benefits & Payroll Taxes			939,889	939,889	37,949	977,838		977,838		22
23	Inservice Training & Education			2,299	2,299		2,299		2,299		23
24	Travel and Seminar			10,169	10,169		10,169		10,169		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			190,125	190,125		190,125		190,125		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	635,446	34,571	2,296,851	2,966,868	(263,557)	2,703,311	(461,389)	2,241,922		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,319,743	630,901	2,819,827	8,770,471	(252,569)	8,517,902	(461,404)	8,056,498		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 &amp; ID Number

Heartland of Peoria

#0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			291,401	291,401	12,922	304,323		304,323			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,379,308	2,379,308	239,647	2,618,955	(2,382,936)	236,019			32
33	Real Estate Taxes			127,435	127,435		127,435		127,435			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			51,544	51,544		51,544		51,544			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,849,688	2,849,688	252,569	3,102,257	(2,382,936)	719,321			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		412,730		412,730		412,730		412,730			39
40	Barber and Beauty Shops			3,924	3,924		3,924		3,924			40
41	Coffee and Gift Shops	23,807			23,807		23,807		23,807			41
42	Provider Participation Fee			278,977	278,977		278,977		278,977			42
43	Other (specify):* <b>IV Therapy/ X-Ray/Lab</b>		45,651	71,786	117,437		117,437		117,437			43
44	<b>TOTAL Special Cost Centers</b>	23,807	458,381	354,687	836,875		836,875		836,875			44
	<b>GRAND TOTAL COST</b>											
45	(sum of lines 29, 37 & 44)	5,343,550	1,089,282	6,024,202	12,457,034		12,457,034	(2,844,340)	9,612,694			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15)	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	(353)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(182)	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	(2,066)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(33,367)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(391,843)	21		24
25	Fund Raising, Advertising and Promotional	(25,258)	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 Schedule 5A	(2,391,256)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,844,340)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,844,340)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Heartland of Peoria

ID# 0049379

Report Period Beginning: 06/01/15

Ending: 05/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(1,047)	21	3
4	Donations Revenue	0	21	4
5	Accounting/Collection Fees	(7,273)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(2,382,936)	32	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
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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	<b>Total</b>	(2,391,256)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

**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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	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	<b>TOTAL General Services</b>	<b>(15)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(40,640)	0	0	0	0	0	0	0	0	0	0	(40,640)	19
20	Fees, Subscriptions & Promotions	(25,258)	0	0	0	0	0	0	0	0	0	0	(25,258)	20
21	Clerical & General Office Expenses	(395,491)	0	0	0	0	0	0	0	0	0	0	(395,491)	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	<b>TOTAL General Administration</b>	<b>(461,389)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(461,389)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(461,404)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(461,404)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	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	(2,382,936)	0	0	0	0	0	0	0	0	0	0	(2,382,936)	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	<b>TOTAL Ownership</b>	<b>(2,382,936)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,382,936)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(2,844,340)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,844,340)</b>	<b>45</b>



**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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 580,454	HCR Manor Care Services, LLC	100.00%	\$ 580,454	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	5,343,550	Heartland Employment Services, LLC	100.00%	5,343,550		4
5	V	10a Therapy Management	16,704	Heartland Rehabilitation Services, LLC	100.00%	16,704		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		\$ 5,940,708			\$ 5,940,708	\$ *	14

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

Facility Name &amp; ID Number

Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

## 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								10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				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:

06/01/15

Ending:

05/31/16

**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 # 0049379 Report Period Beginning: 06/01/15 Ending: 05/31/16

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:

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Ending: 05/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	\$ 818,127	\$ 12,100,119	\$ 2,522	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs		12,100,119	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		12,100,119	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	12,100,119	970
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	12,100,119	7,496
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		12,100,119	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	12,100,119	185,813
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	12,100,119	50,669
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		12,100,119	42,466
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		12,100,119	16,050
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		12,100,119	21,899
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			12,100,119	0
16									16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		12,100,119	10,467
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		12,100,119	2,455
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			12,100,119	0
20									20
21									21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		12,100,119	87,489
23	32	Directly Assigned Interest	Not Allocated			18,868,647			152,158
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797			
25	TOTALS					\$ 177,277,351	\$ 35,285,370	\$ 580,454	25

Facility Name & ID Number

Heartland of Peoria

# 0049379

Report Period Beginning:

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Conv. Sub. Debentures		X				\$ 2,108,942	\$ 2,015,051			0.0755	\$ 152,158	1					
2													2					
3													3					
4													4					
5													5					
	<b>Working Capital</b>																	
6													6					
7	Pooled Interest											87,489	7					
8	Interest Expense / Interest Income											(3,628)	8					
9	<b>TOTAL Facility Related</b>						\$ 2,108,942	\$ 2,015,051				\$ 236,019	9					
	<b>B. Non-Facility Related*</b>																	
10													10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 2,108,942	\$ 2,015,051				\$ 236,019	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.)



## 2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-16-451-008</u>	<u>See Attached</u>	\$ <u>121,548.04</u>	\$ <u>121,548.04</u>
2. <u>14-16-451-009</u>	<u>See Attached</u>	\$ <u>211.26</u>	\$ <u>211.26</u>
3. <u>14-16-451-011</u>	<u>See Attached</u>	\$ <u>1,205.42</u>	\$ <u>1,205.42</u>
4. <u>14-16-451-018</u>	<u>See Attached</u>	\$ <u>819.24</u>	\$ <u>819.24</u>
5. <u>14-16-451-019</u>	<u>See Attached</u>	\$ <u>906.22</u>	\$ <u>906.22</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>124,690.18</u></u>	\$ <u><u>124,690.18</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

06/01/15 Ending:

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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. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 4 columns: Use, Square Feet, Year Acquired, Cost. Rows include Facility, 2004, and TOTALS.

Facility Name & ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

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**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	104		1963	\$ 834,425	\$ 65,820		\$ 65,820	\$	\$ 2,755,723
5	20		1992	1,191,466					
6	10		1998	911,507					
7	10		2002	913,140					
8			2007	365,081					
<b>Improvement Type**</b>									
9	Current Year Depreciation				147,515		147,515		3,378,427
10			1978	65,310					
11			1979	23,480					
12			1981	63,642					
13			1982	10,239					
14			1983	6,057					
15			1984	9,737					
16			1985	9,518					
17			1987	65,867					
18	RETIREMENTS		1987	(33,597)					
19			1988	15,166					
20			1989	176,034					
21			1990	35,994					
22			1991	125,588					
23			1992	134,218					
24	RETIREMENTS		1992	(18,859)					
25			1993	29,944					
26			1994	78,083					
27			1995	97,515					
28			1996	73,410					
29			1997	64,638					
30			1998	55,583					
31			1999	40,160					
32			2000	93,167					
33			2001	532,524					
34									
35									
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 &amp; ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

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Ending:

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	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)		\$ 6,131,120	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	70

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

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# 0049379

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,131,120	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,506,297	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	34

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

Facility Name &amp; ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,506,297	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	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	00000003625 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	00000003649 1306 PARKING (Adjustment to #3638)	2008	1,735						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,254,050	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	34

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

Facility Name &amp; ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,254,050	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	1
2	00000003655 HANDRAILS - HERITAGE WING	2008	11,500						2
3	00000003662 Vinyl Flooring in Patient Rooms	2009	15,226						3
4	00000003663 FRT on Vinyl Flooring	2009	1,070						4
5	00000003665 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)		\$ 7,891,741	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	34

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

Facility Name &amp; ID Number Heartland of Peoria

# 0049379

Report Period Beginning:

06/01/15

Ending:

05/31/16

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 7,891,741	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	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	Prov/install dry pendent SPRINKLER HEAD	2015	31,229						29
30	Prov/inst new DOOR FRAMES in res rooms 200,207,214,217,323,.	2015	12,582						30
31	Removed/installed new life safety panel with 72 circuit panel	2015	11,645						31
32	Replace sheet rock and provide/install new fire-rated FRP board								32
33	panel in kitchen	2015	6,631						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,185,364	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	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:

06/01/15

Ending:

05/31/16

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		\$ 8,185,364	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	1
2	Provide/install wall material to exterior wall. Raise sections								2
3	concrete ramp-main entrance and skim side of ramp wall.	2015	9,280						3
4	Installed 3m Firestop wall material-100 hall	2015	8,787						4
5									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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,203,431	\$ 213,335		\$ 213,335	\$	\$ 6,134,150	34

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



XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,409,760	\$ 78,066	\$ 78,066	\$		\$ 2,239,073	71
72	Current Year Purchases	23,812						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			12,922	12,922			74
75	TOTALS	\$ 2,433,572	\$ 78,066	\$ 90,988	\$ 12,922		\$ 2,239,073	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)	\$ 10,916,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 291,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 304,323	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,922	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,373,223	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 31,078 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	2014 Ford E-150	\$	20,466	17
18					18
19				above figure includes	19
20				gas & maintenance too	20
21	TOTAL		\$	20,466	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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	3843	hrs	\$ 159,200		\$	1,094	3,843	\$ 160,294	1	
2	Licensed Speech and Language Development Therapist	10a	1489	hrs	61,663			1,358	1,489	63,021	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	4430	hrs	183,502			3,809	4,430	187,311	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39, 2		# of prescripts				412,730		412,730	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>IV Therapy</u>	43, 2						45,651		45,651	12	
13	Other (specify): <u>X-Ray / Lab</u>	43, 3						71,786		71,786	13	
14	<b>TOTAL</b>				\$ 404,365		\$	71,786	\$ 464,642	9,762	\$ 940,793	14

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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 25,617	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 594,921 )	1,392,332		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,267		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,423,216	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	279,748		13
14	Buildings, at Historical Cost	8,203,435		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,433,572		16
17	Accumulated Depreciation (book methods)	(8,373,223)		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 (specify) <u>Omit</u>	77,208		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 14,911,809	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 16,335,025	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 153,673	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	442,989		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,299		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payables</u>	111,692		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 822,653	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,015,051		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,015,051	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,837,704	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 13,497,321	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 16,335,025	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>13,364,380</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>13,364,380</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(2,250,153)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (2,250,153)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	2,383,094	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 2,383,094	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 13,497,321	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,245,740	1
2	Discounts and Allowances for all Levels	(4,616,575)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,629,165	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,515,866	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,515,866	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,047	12
13	Barber and Beauty Care	3,218	13
14	Non-Patient Meals	15	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	852,326	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	89,001	19
20	Radiology and X-Ray	63,328	20
21	Other Medical Services	52,562	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,061,497	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purchase Discount</b>	353	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 353	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,206,881	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,340,307	31
32	Health Care	4,463,296	32
33	General Administration	2,966,868	33
<b>B. Capital Expense</b>			
34	Ownership	2,849,688	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	557,898	35
36	Provider Participation Fee	278,977	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,457,034	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,250,153)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,250,153)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,463,103	44
45	Private Pay - Net Inpatient Revenue	1,384,235	45
46	Medicare - Net Inpatient Revenue	293,559	46
47	Other-(specify) <u>Hospice</u>	501,052	47
48	Other-(specify) <u>Insurance</u>	987,216	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,629,165	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:

06/01/15

Ending:

05/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,863	2,023	\$ 96,070	\$ 47.49	1
2	Assistant Director of Nursing	8,573	9,309	303,316	32.58	2
3	Registered Nurses	14,475	15,718	471,902	30.02	3
4	Licensed Practical Nurses	33,197	36,047	811,224	22.50	4
5	CNAs & Orderlies	89,182	97,148	1,141,206	11.75	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,429	13,494	558,932	41.42	7
8	Rehab/Therapy Aides	15,457	16,781	478,989	28.54	8
9	Activity Director	5,082	5,525	87,255	15.79	9
10	Activity Assistants					10
11	Social Service Workers	5,105	5,541	128,782	23.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,997	23,920	272,707	11.40	15
16	Dishwashers					16
17	Maintenance Workers	1,940	2,110	58,681	27.81	17
18	Housekeepers	15,492	16,843	195,165	11.59	18
19	Laundry	4,286	4,659	44,289	9.51	19
20	Administrator	2,080	2,080	108,003	51.92	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,583	23,405	527,443	22.54	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	1,967	2,138	35,779	16.73	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,846	2,006	23,807	11.87	33
34	TOTAL (lines 1 - 33)	256,554	278,747	\$ 5,343,550 *	\$ 19.17	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	29,475	9, 3	36
37	Medical Records Consultant	24	1,781	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)	24	\$ 31,256		49

**C. CONTRACT NURSES**

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





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**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 \$3,558 & ACHA \$2,049
- (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. \$ 62,845 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. \$ 278,977  
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. \$ 15
- (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