

Facility Name & ID Number Heartland of Peoria

0049379 Report Period Beginning: 6/1/08 Ending: 5/31/09

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	52,560	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	10,742	12,324	23,340	46,406	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,742	12,324	23,340	46,406	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.29%

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)

N/A

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 11/01/81 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 15,235

Medicare Intermediary HighMark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 05/31/09

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

Facility Name & ID Number Heartland of Peoria # 0049379 Report Period Beginning: 6/1/08 Ending: 5/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,736	28,594	74,597	358,927	3,050	361,977		361,977		1
2	Food Purchase		335,198		335,198		335,198	(826)	334,372		2
3	Housekeeping	189,848	28,147	815	218,810		218,810		218,810		3
4	Laundry	43,507	10,013	241	53,761		53,761		53,761		4
5	Heat and Other Utilities			234,804	234,804	5,781	240,585	(9,153)	231,432		5
6	Maintenance	77,122	30,421	94,669	202,212		202,212		202,212		6
7	Other (specify):* Med Waste			798	798		798		798		7
8	TOTAL General Services	566,213	432,373	405,924	1,404,510	8,831	1,413,341	(9,979)	1,403,362		8
	B. Health Care and Programs										
9	Medical Director			20,700	20,700		20,700		20,700		9
10	Nursing and Medical Records	2,765,379	233,496	236,011	3,234,886	4,890	3,239,776	(33,633)	3,206,143		10
10a	Therapy	1,153,537	16,613	281,923	1,452,073		1,452,073		1,452,073		10a
11	Activities	115,275	15,343	6,707	137,325		137,325	(102)	137,223		11
12	Social Services	207,687	2	2,242	209,931		209,931		209,931		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,241,878	265,454	547,583	5,054,915	4,890	5,059,805	(33,735)	5,026,070		16
	C. General Administration										
17	Administrative	116,266		532,601	648,867	(187,164)	461,703		461,703		17
18	Directors Fees										18
19	Professional Services			25,262	25,262		25,262	(25,262)			19
20	Dues, Fees, Subscriptions & Promotions			123,552	123,552		123,552	(55,680)	67,872		20
21	Clerical & General Office Expenses	385,746	67,027	123,933	576,706		576,706	(55,295)	521,411		21
22	Employee Benefits & Payroll Taxes			914,679	914,679	51,259	965,938		965,938		22
23	Inservice Training & Education			5,459	5,459		5,459		5,459		23
24	Travel and Seminar			32,037	32,037		32,037		32,037		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			215,629	215,629		215,629		215,629		26
27	Other (specify):*										27
28	TOTAL General Administration	502,012	67,027	1,973,152	2,542,191	(135,905)	2,406,286	(136,237)	2,270,049		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,310,103	764,854	2,926,659	9,001,616	(122,184)	8,879,432	(179,951)	8,699,481		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:

6/1/08

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			419,426	419,426	15,781	435,207		435,207			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(3,172)	(3,172)	106,403	103,231		103,231			32
33	Real Estate Taxes			111,708	111,708		111,708	3,532	115,240			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			176,537	176,537		176,537		176,537			35
36	Other (specify):*											36
37	TOTAL Ownership			704,499	704,499	122,184	826,683	3,532	830,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,148	1,148		1,148		1,148			38
39	Ancillary Service Centers		492,150		492,150		492,150		492,150			39
40	Barber and Beauty Shops			12,138	12,138		12,138		12,138			40
41	Coffee and Gift Shops	87,320			87,320		87,320		87,320			41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):*		40,323	75,914	116,237		116,237		116,237			43
44	TOTAL Special Cost Centers	87,320	532,473	168,256	788,049		788,049		788,049			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,397,423	1,297,327	3,799,414	10,494,164		10,494,164	(176,419)	10,317,745			45

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

Heartland of Peoria

ID# 0049379

Report Period Beginning: 6/1/08

Ending: 5/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (252)	21	1
2	Activities Income	(102)	11	2
3	Transportation Expense	(33,633)	10	3
4				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				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	(33,987)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Peoria# 0049379

Report Period Beginning:

6/1/08

Ending:

5/31/09

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

	Operating Expenses	PAGES	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	(826)	0	0	0	0	0	0	0	0	0	0	(826)	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	(9,153)	0	0	0	0	0	0	0	0	0	0	(9,153)	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	(9,979)	0	(9,979)	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	(33,633)	0	0	0	0	0	0	0	0	0	0	(33,633)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(102)	0	0	0	0	0	0	0	0	0	0	(102)	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	(33,735)	0	(33,735)	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	(25,262)	0	0	0	0	0	0	0	0	0	0	(25,262)	19
20	Fees, Subscriptions & Promotions	(55,680)	0	0	0	0	0	0	0	0	0	0	(55,680)	20
21	Clerical & General Office Expenses	(55,295)	0	0	0	0	0	0	0	0	0	0	(55,295)	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	(136,237)	0	(136,237)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,951)	0	(179,951)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Peoria# 0049379

Report Period Beginning:

6/1/08

Ending:

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

	Capital Expense	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)	
	D. Ownership													
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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	3,532	0	0	0	0	0	0	0	0	0	0	3,532	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	3,532	0	0	0	0	0	0	0	0	0	0	3,532	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(176,419)	0	0	0	0	0	0	0	0	0	0	(176,419)	45

Facility Name & ID Number

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0049379

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Ending:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America	Toledo, OH			
		See H.O. Cost Report				

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	\$ 532,602	HCR ManorCare, Inc.	100.00%	\$ 532,602	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	49,096	Heartland Management Services	100.00%	49,096		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 581,698			\$ 581,698	\$ *	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: 6/1/08 Ending: 5/31/09

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit Street
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419-252-5500
 Fax Number (419-252-5495

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	1	Dietary - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	\$ 1,686	\$ 9,013,032	\$ 6	1	
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,103,816	559,529	9,013,032	3,044	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	287,502		9,013,032	939	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,755,769		9,013,032	4,842	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			9,013,032	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,773,058	1,106,606	9,013,032	4,890	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	30,646,209	36,538,442	9,013,032	100,104	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	88,964,011	51,489,483	9,013,032	245,334	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	6,188,752		9,013,032	20,215	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	11,257,416		9,013,032	31,044	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			9,013,032	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	5,722,441		9,013,032	15,781	12
13										13
14	32	Interest							106,403	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 147,700,660	\$ 89,694,060	\$	532,602	25

Facility Name & ID Number

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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	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			
A. Directly Facility Related																			
Long-Term																			
1	Conv Sub Debentures	X	Facility			\$ 897,108	\$ 897,108			\$	1								
2	National City Bank, Trustee					1,211,834	1,211,834				2								
3	Combined Interest									106,403	3								
4											4								
5											5								
Working Capital																			
6											6								
7								Interest Income		(3,172)	7								
8											8								
9	TOTAL Facility Related					\$ 2,108,942	\$ 2,108,942			\$ 103,231	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			\$ 103,231	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	104,645	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.)		\$	108,177	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,532	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,708	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.		\$	115,240	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	88,926	8	
	2005	93,438	9	
	2006	97,291	10	
	2007	104,645	11	
	2008	111,708	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Care Health Services - Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 6000293

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE 419-252-5740 FAX #: 419-254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>14-16-451-008</u>	<u>See Attached</u>	\$ <u>54,687.87</u>	\$ <u>54,687.87</u>
2.	<u>14-16-451-009</u>	<u>See Attached</u>	\$ <u>95.84</u>	\$ <u>95.84</u>
3.	<u>14-16-451-011</u>	<u>See Attached</u>	\$ <u>373.25</u>	\$ <u>373.25</u>
4.	<u>14-16-451-018</u>	<u>See Attached</u>	\$ <u>353.07</u>	\$ <u>353.07</u>
5.	<u>14-16-451-019</u>	<u>See Attached</u>	\$ <u>343.83</u>	\$ <u>343.83</u>
6.	<u>14-16-451-008</u>	<u>See Attached</u>	\$ <u>54,687.87</u>	\$ <u>54,687.87</u>
7.	<u>14-16-451-009</u>	<u>See Attached</u>	\$ <u>95.84</u>	\$ <u>95.84</u>
8.	<u>14-16-451-011</u>	<u>See Attached</u>	\$ <u>373.25</u>	\$ <u>373.25</u>
9.	<u>14-16-451-018</u>	<u>See Attached</u>	\$ <u>353.07</u>	\$ <u>353.07</u>
10.	<u>14-16-451-019</u>	<u>See Attached</u>	\$ <u>343.83</u>	\$ <u>343.83</u>
		TOTALS	\$ <u>111,707.72</u>	\$ <u>111,707.72</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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

6/1/08

Ending:

5/31/09

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1981,1998, 20	\$ 236,851	1
2			2004	42,897	2
3	TOTALS			\$ 279,748	3

Facility Name & ID Number Heartland of Peoria

0049379

Report Period Beginning:

6/1/08

Ending:

5/31/09

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104			1963	\$ 834,425	\$ 89,766		\$ 89,766	\$	\$ 2,237,356	4
5	20			1992	1,191,466						5
6	10			1998	911,507						6
7	10			2002	913,140						7
8	PT Addition			2007	365,081						8
	Improvement Type**										
9	Building Improvements (Current year depreciation)			1978	65,310	212,117		212,117		2,197,566	9
10				1979	23,480						10
11				1981	63,642						11
12				1982	10,239						12
13				1983	6,057						13
14				1984	9,737						14
15				1985	9,518						15
16				1987	65,867						16
17				1987	(33,597)						17
18	RETIREMENTS			1988	15,166						18
19				1989	176,034						19
20				1990	35,994						20
21				1991	125,588						21
22				1992	134,218						22
23				1992	(18,859)						23
24	RETIREMENTS			1993	29,944						24
25				1994	78,083						25
26				1995	44,937						26
27				1995	5,075						27
28	ELECTRICAL WORK			1995	5,237						28
29	CARPET			1995	18,789						29
30	PAINTING			1995	7,203						30
31	WALL VINYL			1995	2,283						31
32	CERAMIC TILE & INSTALLATION			1995	4,388						32
33	BATHROOM RENOVATION			1995	6,989						33
34	BATHROOM RENOVATION			1995	689						34
35	FIRE ALARMS/SMOKE DETECTORS			1995	500						35
36	HVAC WORK										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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	PAVING/REPAIRS	1995	\$ 1,425	\$		\$	\$	\$	37
38	CAPITALIZED LABOR-BATHROOM	1996	7,272						38
39	CR 5/31/99 AUDIT ADJ-CAPITAL LABOR	1996	(7,272)						39
40	ROOF WORK	1996	1,374						40
41	HOLDING TANK/VALVES	1996	1,942						41
42	DOORS	1996	398						42
43	CARPET	1996	13,137						43
44	TILE	1996	2,036						44
45	WALLCOVERINGS	1996	11,574						45
46	INSTALL TWO BOILERS	1996	12,289						46
47	HERITAGE RENOVATIONS	1996	7,965						47
48	ELECTRICAL/LIGHTING	1996	1,611						48
49	INSTALL CABINETS	1996	12,758						49
50	HEATING/AC WORK	1996	3,759						50
51	EXIT DEVICES	1996	1,765						51
52	DOORS/SIGNS	1996	2,802						52
53	LIGHTING	1997	1,572						53
54	CARPET & INSTALLATION	1997	3,230						54
55	SIDING	1997	2,335						55
56	WALLCOVERINGS	1997	6,104						56
57	INSTALL EXHAUST FAN/LIGHT	1997	2,211						57
58	NITEL SX-200 SYSTEM	1997	23,641						58
59	PAGING SYSTEM	1997	5,333						59
60	ROOFTOP A/C	1997	10,968						60
61	CARPET	1997	829						61
62	CEILING WORK	1997	2,385						62
63	ROOF REPAIRS	1997	2,177						63
64	ALLOC FAC. PLAN-HERITAGE	1997	2,758						64
65	CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1997	(2,758)						65
66	ELECTRIC	1997	2,687						66
67	WATER HEATER/WATER LINE	1997	1,166						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,247,607	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,247,607	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	FLOORING/CEILING	1998	3,448						2
3	CARPETING	1998	3,020						3
4	PAINTING	1998	3,020						4
5	WALLCOVERINGS	1998	3,020						5
6	INSTALL HANDRAILS	1998	4,875						6
7	INSTALL DOORS/LOCKS	1998	2,820						7
8	CORPORATE OVERHEAD-HERITAGE ADDTN	1998	1,702						8
9	CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1998	(1,702)						9
10	FINISH/STUD	1998	45,863						10
11	CR 5/31/03 AUDIT ADJ 2A-RELCASS FINISH/STUD TO BUILDING	1998	(45,863)						11
12	SITE/DEMOLITION	1998	86,230						12
13	CR 5/31/03 AUDIT ADJ 2B-SITE/DEMOLITION	1998	(86,230)						13
14	LANDSCAPING	1998	5,310						14
15	ROOFING	1998	53,000						15
16	CR 5/31/03 AUDIT ADJ 2C-ROOFING	1998	(53,000)						16
17	ELECTRICAL	1998	841						17
18	AIR CONDITIONING	1998	5,617						18
19	CARPETING	1998	1,994						19
20	GENERAL CONTRACTOR-HERITAGE ADDTN	1998	2,524						20
21	CR 5/31/03 AUDIT ADJ 2D-CONTRACTOR FEES	1998	(2,524)						21
22	PAINTING/WALLCOVERING	1998	531						22
23	PLUMBING	1998	7,900						23
24	SIGNAGE	1998	11,862						24
25	GAZEBO	1998	1,325						25
26	50 GAL AMTEK	1999	1,699						26
27	AIR CONDITIONING	1999	1,940						27
28	LAND IMPROVEMENTS-ARCADIA REN	1999	6,099						28
29	LAND IMPROVEMENTS-ARCADIA REN	1999	315						29
30	CONCRETE PAD	1999	713						30
31	EXIT DOOR ALARM	1999	547						31
32	RUSKIN PAMPER	1999	896						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,315,399	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,315,399	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	HOT WATER LINE	1999	780						2
3	FURNISHINGS	1999	557						3
4	CR 5/31/03 AUDIT ADJ-FURNISHINGS	1999	(557)						4
5	SMOKING SHELTER	1999	4,950						5
6	BUILDING IMPROVEMENTS-ARCADIA	1999	1,821						6
7	BUILDING IMPROVEMENTS-ARCADIA	1999	780						7
8	LOCKS	1999	4,509						8
9	SMOKING SHELTER	1999	4,950						9
10	RETENTION	1999	29,415						10
11	CR 5/31/03 AUDIT ADJ 3A-RETENTION	1999	(29,415)						11
12	CAMERA SECURITY	1999	3,469						12
13	DOOR	1999	1,011						13
14	FLOOR	1999	774						14
15	ENGINEER/DESIGNER FEES-ARCADIA RENOV	1999	693						15
16	ELECTRICAL CONTRACT-ARCADIA RENOV	1999	450						16
17	PIPING	1999	2,730						17
18	HVAC	1999	1,034						18
19	SECURITY SYSTEM-SECOND HALF	2000	3,468						19
20	FLOOR TILE-RESIDENT ROOM	2000	3,870						20
21	POWERS VALVE	2000	670						21
22	SECURE CARE	2000	1,019						22
23	CR 5/31/03 AUDIT ADJ 3C-RECLASS FROM 2001	2000	40,091						23
24	CR 5/31/03 AUDIT ADJ 3D-RECLASS FROM 2001	2000	29,375						24
25	CR 5/31/03 AUDIT ADJ 3F-RECLASS FROM 2001	2000	14,674						25
26	A/C DUCTLESS SYSTEM	2001	3,774						26
27	VCT - DINING ROOM	2001	4,168						27
28	PAINTING / RETAINAGE	2001	98						28
29	PAINTING	2001	882						29
30	PAINTING	2001	1,000						30
31	GENERAL OVERHEAD-MEDICARE RENOV	2001	57,004						31
32	CR 5/31/03 AUDIT ADJ 3B-GENERAL OVERHEAD	2001	(57,004)						32
33	DRAPES,SHADES,BLINDS	2001	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 5,457,101	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,457,101	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	CEILING,KICKERBOARD-MEDICARE RENOV	2001	31,746						2
3	CARPET,PAINT,WALLPAPER-MEDICARE RENOV	2001	59,734						3
4	CR 5/31/03 AUDIT ADJ 3C-MEDICARE RENOV	2001	(485)						4
5	CR 5/31/03 AUDIT ADJ 3C-RECLASS TO 2000	2001	(40,091)						5
6	HVAC AND ELECTRICAL	2001	7,683						6
7	PAINT, WALLPAPER	2001	3,470						7
8	DRYWALL,DOOR,CARPENTRY-ARCADIA RENOV	2001	34,121						8
9	WALLPAPER,CARPET-ARCADIA RENOV	2001	58,729						9
10	CR 5/31/03 AUDIT ADJ 3D-ARCADIA RENOV	2001	(4,989)						10
11	CR 5/31/03 AUDIT ADJ 3D-RECLASS TO 2000	2001	(29,375)						11
12	PAINTING-ARCADIA RENOV	2001	12,554						12
13	PLUMBING,ELECTRICAL-ARCADIA RENOV	2001	107,746						13
14	GENERAL OVERHEAD-ARCADIA RENOV	2001	150,192						14
15	CR 5/31/03 AUDIT ADJ 3E-ARCADIA RENOV	2001	(150,192)						15
16	DRAPES,ARTWORK-ARCADIA RENOV	2001	21,753						16
17	CR 5/31/03 AUDIT ADJ 3F-ARCADIA RENOV	2001	(844)						17
18	CR 5/31/03 AUDIT ADJ 3F- RECLASS TO EQUIPMENT	2001	(6,235)						18
19	CR 5/31/03 AUDIT ADJ 3F-RECLASS TO 2000	2001	(14,674)						19
20	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	9,000						20
21	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	4,250						21
22	FLOORING	2001	18,030						22
23	FLOORING	2001	1,052						23
24	CARPET,VINYL WALL COVERING	2001	11,143						24
25	ROOF	2001	184,141						25
26	CR 5/31/03 AUDIT ADJ 4B-OVERHEAD	2001	(1,800)						26
27	CR 5/31/03 AUDIT ADJ 4B-INTEREST	2001	(345)						27
28	SOIL/CONCRETE TEST, FEES	2001	15,756						28
29	GC - SITE WORK	2001	269,327						29
30	CR 5/31/03 AUDIT ADJ 4C- RECLASS TO BUILDING	2001	(239,457)						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,969,041	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,969,041	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	VWC,FLOORING	2002	8,790						2
3	CABINETS	2002	9,529						3
4	ADDTL CONSTRUCTION COST	2002	117						4
5	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(117)						5
6	ADDTL CONSTRUCTION COST	2002	560						6
7	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(560)						7
8	ADDTL CONSTRUCTION COST	2002	109						8
9	WINDOW TREATMENTS	2002	7,067						9
10	ROOFING	2002	1,486						10
11	ADDTL COSTS OF ARCADIA RE	2002	1,274						11
12	ADDTL COSTS OF ARCADIA RE	2002	2,867						12
13	VCT FLOORING	2002	1,484						13
14	VCT FLOORING	2002	1,367						14
15	VCT FLOORING	2002	1,192						15
16	RETAINAGE ON NEW CONSTRUCTION	2002	5,000						16
17	CR 5/31/03 AUDIT ADJ 5B-RETAINAGE	2002	(5,000)						17
18	VWC,FLOORING	2002	1,182						18
19	VWC	2003	133						19
20	FLOORING / WALLCOVERING	2003	95,423						20
21	VWC	2003	685						21
22	FREIGHT ON VWC	2003	433						22
23	KITCHEN DOOR	2003	2,874						23
24	VCT FLOORING	2003	1,110						24
25	VWC & PAINTING	2004	3,500						25
26	AWNING	2004	2,950						26
27	FENCED IN COURTYARD	2005	10,500						27
28	INSTALL GUTTER	2005	5,800						28
29	VINYL WALL COVERING	2004	220						29
30	VINYL WALL COVERING	2004	297						30
31	VINYL WALL COVERING	2004	241						31
32	VINYL WALL COVERING	2004	206						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,129,758	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,129,758	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	VINYL WALL COVERING	2004	362						2
3	VINYL WALL COVERING	2004	1,004						3
4	INSTALL CABINETS	2004	10,272						4
5	PAINTING AND WALLCOVERING	2004	7,200						5
6	VINYL WALL COVERING	2004	1,593						6
7	VINYL TILE AND VINYL WALL COVERING	2004	10,000						7
8	VINYL TILE AND VINYL WALL COVERING	2004	274						8
9	PAINTING AND WALLCOVERING	2005	800						9
10	VINYL WALL COVERING	2004	1,004						10
11	LABOR, PERMITS FOR REHAB ROOM RENOV	2004	2,650						11
12	PAINT DOORS, FRAMES, HEATERS	2004	5,800						12
13	NORSTAR PHONE SYSTEM	2005	18,681						13
14	CUSTOM CABINETS	2005	11,770						14
15	ARCH & ENGINEERING COST	2005	665						15
16	ARCH & ENGINEERING COST	2005	456						16
17	ARCH & ENGINEERING COST	2005	3,585						17
18	CARPET	2005	5,524						18
19	PLUMBING FOR KITCHEN	2004	2,440						19
20	ELECTRICAL FOR KITCHEN	2004	1,975						20
21	FIRE DOOR	2005	4,706						21
22	CARPET	2005	3,060						22
23	CARPET	2005	1,087						23
24	WATER LINES	2005	27,419						24
25	PLUMBING	2005	3,047						25
26	ARCHITECTURAL DRAWINGS	2005	5,623						26
27	WALLCOVERING	2005	1,337						27
28	FIVE HOLLOW METAL DOORS/FRAMES	2006	8,370						28
29	HOLLOW METAL DOOR	2006	1,431						29
30	CARPETING/WALLCOVERING	2006	9,473						30
31	CARPENTRY FOR HALL/OFFICE/LOBBY REN	2006	85,850						31
32	ELECTRICAL FOR FIRE ALARM	2006	3,472						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,370,688	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,370,688	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	FRAME, DRYWALL	2006	3,900						2
3	OVERHEAD & INTEREST	2006	6,737						3
4	FIRE SPRINKLER SYSTEM	2006	124,976						4
5	VINYL TILE	2006	6,500						5
6	CARPET FOR AC CORRIDOR	2006	6,878						6
7	GENERATOR-ENGINEER COSTS, OH & INT	2006	32,929						7
8	GENERATOR-PLAN REVIEWS	2006	2,400						8
9	GENERATOR-ELECTRICAL	2006	209,851						9
10	PT ADDITION-ARCHITECT & ENGINEER COSTS	2007	48,702						10
11	PT ADDITION-GENERAL OVERHEAD	2007	44,998						11
12	PT ADDITION-PLAN REVIEWS	2007	5,553						12
13	PT ADDITION-INTEREST	2007	4,210						13
14	CARPETING, WALL COVERING	2007	5,559						14
15	FIRE SPRINKLER SYSTEM	2007	4,000						15
16	SITE PREP, CONCRETE	2007	19,735						16
17	CONCRETE TESTING	2007	4,395						17
18	LEGAL FEES-SITE PREP	2007	17,853						18
19	1107 SIDEWALK FROM BASEME	2007	44,050						19
20	PRCH PR ADJ 402 013-06C - PARKING (#21)	2007	(1,890)						20
21	1306 PARKING	2007	1,890						21
22	1306 PARKING	2008	170,319						22
23	CARPENTRY IN BASEMENT	2007	4,410						23
24	5 DOORS	2007	4,143						24
25	wallcovering	2007	2,740						25
26	DOORS FOR FIRE DAMPERS	2007	1,387						26
27	CARPET 316, 318, 320, 329	2007	2,046						27
28	WALLPAPER IN MAIN DINING	2007	3,915						28
29	00000003625 FLOORING	2007	5,756						29
30	0207 EMERGENCY EGRESS LIG	2007	8,029						30
31	0207 EMERGENCY EGRESS LIG	2007	66,550						31
32	1107 SIDEWALK FROM BASEME	2007	6,429						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,239,638	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,239,638	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	1
2	2007	264						2
3	2007	(264)						3
4	2008	12,681						4
5	2008	1,735						5
6	2008	11,500						6
7	2009	15,226						7
8	2009	1,070						8
9	2009	20,343						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		\$ 7,302,193	\$ 301,883		\$ 301,883	\$	\$ 4,434,922	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:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,841,473	\$ 117,543	\$ 117,543	\$		\$ 1,525,347	71
72	Current Year Purchases	96,373						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			15,781	15,781			74
75	TOTALS	\$ 1,937,846	\$ 117,543	\$ 133,324	\$ 15,781		\$ 1,525,347	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,519,787	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 419,426	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 435,207	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,781	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,960,269	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:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 176,537 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Bed., 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	10,694 hrs	\$ 399,197	5,250	\$ 131,259	\$ 3,246	15,944	\$ 533,702	1
2	Licensed Speech and Language Development Therapist	10a	3,950 hrs	147,462	310	7,741	194	4,260	155,397	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	16,216 hrs	605,347	5,805	142,923	13,173	22,021	761,443	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	5,39,2	# of prescripts				492,150		492,150	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>P/S X-Ray & Lab</u>	5,43,2				75,914			75,914	13
14	TOTAL			\$ 1,152,006	11,365	\$ 357,837	\$ 508,763	42,225	\$ 2,018,606	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.

Facility Name & ID Number Heartland of Peoria# 0049379Report Period Beginning: 6/1/08Ending: 5/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (964)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,944,705		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,405		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,948,146	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	279,748		13
14	Buildings, at Historical Cost	7,302,193		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,937,846		16
17	Accumulated Depreciation (book methods)	(5,960,269)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	26,297		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,585,815	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,533,961	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 97,980	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	552,868		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,708		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Acc Payables</u>	198,070		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 960,626	\$	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)	\$ 3,069,568	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,464,393	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,533,961	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):	3,836,424	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,836,424	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,703,216	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,703,216	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(4,075,247)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,075,247)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,464,393	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,540,023	1
2	Discounts and Allowances for all Levels	(1,785,899)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,754,124	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,656,036	6
7	Oxygen	42,576	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,698,612	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	795	12
13	Barber and Beauty Care	11,385	13
14	Non-Patient Meals	31	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	534,618	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	153,786	19
20	Radiology and X-Ray	30,249	20
21	Other Medical Services	13,388	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 744,252	23
D. Non-Operating Revenue			
24	Contributions	140	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 140	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	252	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 252	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,197,380	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,404,510	31
32	Health Care	5,054,915	32
33	General Administration	2,542,191	33
B. Capital Expense			
34	Ownership	704,499	34
C. Ancillary Expense			
35	Special Cost Centers	788,049	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,494,164	40
41	Income before Income Taxes (line 30 minus line 40)**	2,703,216	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,703,216	43

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

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

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

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

Facility Name & ID Number Heartland of Peoria

0049379

Report Period Beginning:

6/1/08

Ending:

5/31/09

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	1,367	1,472	\$ 53,368	\$ 36.26	1
2	Assistant Director of Nursing	14,245	15,336	437,680	28.54	2
3	Registered Nurses	7,492	8,065	228,235	28.30	3
4	Licensed Practical Nurses	39,052	42,042	925,672	22.02	4
5	CNAs & Orderlies	93,950	101,422	1,164,094	11.48	5
6	CNA Trainees					6
7	Licensed Therapist	10,578	11,507	429,548	37.33	7
8	Rehab/Therapy Aides	24,413	26,556	647,617	24.39	8
9	Activity Director					9
10	Activity Assistants	8,057	8,705	115,275	13.24	10
11	Social Service Workers	9,868	10,635	207,687	19.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,644	24,467	255,736	10.45	15
16	Dishwashers					16
17	Maintenance Workers	3,780	4,083	77,122	18.89	17
18	Housekeepers	19,261	20,827	189,848	9.12	18
19	Laundry	4,983	5,379	43,507	8.09	19
20	Administrator	2,080	2,080	78,886	37.93	20
21	Assistant Administrator	1,522	1,522	37,380	24.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,660	21,486	386,714	18.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,113	2,283	32,702	14.32	31
32	Other Health Care(specify)	8,358	9,031		0.00	32
33	Other(specify)			86,352		33
34	TOTAL (lines 1 - 33)	293,423	316,898	\$ 5,397,423 *	\$ 17.03	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			36
37	Medical Records Consultant	Monthly 1,380	5, 10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 5,660	5,9,3	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)	Monthly 64,740	5, 10,3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 71,780		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,205 \$ 34,101	5,10,3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	6,100 70,024	5,10,3	52
53	TOTAL (lines 50 - 52)	7,305 \$ 104,125		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. IHCA \$4010
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 78,219 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? No
If YES, give effective date of lease. _____
- (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. \$ 79,056
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. \$ 31
- (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? Yes
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.