

Facility Name & ID Number Heartland of Peoria

0049379 Report Period Beginning: 06/01/17 Ending: 05/31/18

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 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	22,398	2,847	11,293	36,538	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,398	2,847	11,293	36,538	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.52%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 4,250

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.

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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	253,357	20,911	54,172	328,440		328,440		328,440		1
2	Food Purchase		247,157		247,157		247,157	(25)	247,132		2
3	Housekeeping	187,159	19,246	1,473	207,878		207,878		207,878		3
4	Laundry	40,980	58,552	308	99,840		99,840		99,840		4
5	Heat and Other Utilities			212,664	212,664	2,465	215,129		215,129		5
6	Maintenance	77,320	14,049	82,936	174,305		174,305		174,305		6
7	Other (specify):* Medical Waste			617	617		617		617		7
8	TOTAL General Services	558,816	359,915	352,170	1,270,901	2,465	1,273,366	(25)	1,273,341		8
	B. Health Care and Programs										
9	Medical Director			28,600	28,600		28,600		28,600		9
10	Nursing and Medical Records	3,129,466	216,076	122,009	3,467,551	56	3,467,607		3,467,607		10
10a	Therapy	1,030,658	11,029	2,349	1,044,036		1,044,036		1,044,036		10a
11	Activities	97,284	3,004	5,563	105,851		105,851		105,851		11
12	Social Services	153,624	54	4,228	157,906		157,906		157,906		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,411,032	230,163	162,749	4,803,944	56	4,804,000		4,804,000		16
	C. General Administration										
17	Administrative	119,048		634,905	753,953	(310,195)	443,758		443,758		17
18	Directors Fees										18
19	Professional Services			79,455	79,455	(475)	78,980	(78,980)			19
20	Dues, Fees, Subscriptions & Promotions			79,039	79,039		79,039	(16,696)	62,343		20
21	Clerical & General Office Expenses	389,419	45,241	957,746	1,392,406	475	1,392,881	(872,543)	520,338		21
22	Employee Benefits & Payroll Taxes			797,231	797,231	45,671	842,902		842,902		22
23	Inservice Training & Education			3,283	3,283		3,283		3,283		23
24	Travel and Seminar			6,945	6,945		6,945		6,945		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			703,468	703,468		703,468		703,468		26
27	Other (specify):*										27
28	TOTAL General Administration	508,467	45,241	3,262,072	3,815,780	(264,524)	3,551,256	(968,219)	2,583,037		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,478,315	635,319	3,776,991	9,890,625	(262,003)	9,628,622	(968,244)	8,660,378		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			217,110	217,110	15,139	232,249		232,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,381,845	2,381,845	246,864	2,628,709	(2,391,027)	237,682			32
33	Real Estate Taxes			128,615	128,615		128,615		128,615			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			63,103	63,103		63,103		63,103			35
36	Other (specify):*											36
37	TOTAL Ownership			2,790,673	2,790,673	262,003	3,052,676	(2,391,027)	661,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		348,688		348,688		348,688		348,688			39
40	Barber and Beauty Shops		6	5,873	5,879		5,879		5,879			40
41	Coffee and Gift Shops	33,473			33,473		33,473		33,473			41
42	Provider Participation Fee			246,577	246,577		246,577		246,577			42
43	Other (specify):* IV X-Ray & Lab		32,386	68,464	100,850		100,850		100,850			43
44	TOTAL Special Cost Centers	33,473	381,080	320,914	735,467		735,467		735,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,511,788	1,016,399	6,888,578	13,416,765		13,416,765	(3,359,271)	10,057,494			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	(25)	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	(172)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(95)	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	(33,313)	21		18
19	Entertainment				19
20	Contributions	(2,038)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(61,063)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(835,651)	21		24
25	Fund Raising, Advertising and Promotional	(16,696)	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 Pg. 5A	(2,410,218)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,359,271)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,359,271)		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	Exeptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heartland of Peoria

ID# 0049379

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(1,274)	21	3
4	Donations Revenue	0	21	4
5	Accounting/Collection Fees	(17,917)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(2,391,027)	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
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,410,218)		49

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
				HCR Manor Care Svcs	Toledo	Therapy Mgmt Svcs
				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	\$ 634,905	HCR Manor Care Services, LLC	0.00%	\$ 634,905	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,511,788	Heartland Employment Services, LLC	0.00%	5,511,788		4
5	V	10a	Therapy Management	20,286	HCR Manor Care Services, LLC	0.00%	20,286		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 6,166,979			\$ 6,166,979	\$ *		14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				12
13			Manor Care of Hinsdale IL, LLC	Hinsdale				13
14			Manor Care of Homewood IL, LLC	Homewood				14
15			Manor Care of Libertyville IL, LLC	Libertyville				15
16			Manor Care of Naperville IL, LLC	Naperville				16
17			Manor Care of Northbrook IL, LLC	Northbrook				17
18			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				18
19			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				19
20			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				20
21			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				21
22			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				22
23			Manor Care of South Holland IL, LLC	South Holland				23
24			Manor Care of Westmont IL, LLC	Westmont				24
25			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				25
26			Arden Courts of Geneva IL, LLC	Geneva				26
27			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				27
28			Arden Courts of Northbrook IL, LLC	Northbrook				28
29			Arden Courts of Palos Heights IL, LLC	Palos Heights				29
30			Arden Courts of South Holland IL, LLC	South Holland				30

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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

Name of Related Organization HCR Manor Care Services LLC
 Street Address 333 North Summit 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	560 NFs, HHs, & Re	\$ 699,205	\$ 0	13,180,016	\$ 2,465	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	13,180,016	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	13,180,016	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	560 NFs, HHs, & Re	16,031	10,238	13,180,016	56	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	13,180,016	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	13,180,016	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	560 NFs, HHs, & Re	59,973,786	32,867,234	13,180,016	211,461	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	359 NFs	16,450,188	6,362,586	13,180,016	66,808	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	72 NFs	2,602,958	0	13,180,016	46,441	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	560 NFs, HHs, & Re	5,900,308	0	13,180,016	20,804	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	359 NFs	6,123,085	0	13,180,016	24,867	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	72 NFs	0	0	13,180,016	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	560 NFs, HHs, & Re	3,462,953	0	13,180,016	12,210	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	359 NFs	721,157	0	13,180,016	2,929	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	13,180,016	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,591,078		13,180,016	100,809	22
23	32	Directly Assigned Interest	Not Allocated		16,243,764			146,055	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			34,016,444				24
25	TOTALS				\$ 174,800,957	\$ 39,240,058		\$ 634,905	25

Facility Name & ID Number

Heartland of Peoria

0049379

Report Period Beginning:

06/01/17

Ending:

05/31/18

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			
	A. Directly Facility Related																	
	Long-Term																	
1	Conv. Sub. Debentures		X				\$ 2,108,942	\$ 1,887,254			0.0774	\$ 146,055	1					
2													2					
3													3					
4													4					
5													5					
	Working Capital																	
6	Home Office Pooled Interest Expense											100,809	6					
7	Interest Income / Interest Expense											(9,182)	7					
8													8					
9	TOTAL Facility Related						\$ 2,108,942	\$ 1,887,254				\$ 237,682	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	\$ 1,887,254				\$ 237,682	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.)

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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 bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.	\$	116,743	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.)	\$	127,785	2
3. Under or (over) accrual (line 2 minus line 1).	\$	11,041	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	117,574	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.	\$	128,615	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	116,728	8
	2014	118,103	9
	2015	124,690	10
	2016	127,307	11
	2017	128,262	12

Line 2: \$127,784.69 = \$63,653.62 for 2nd half 2016 + \$64,131.07 for 1st half 2017

Line 4: \$117,573.57= \$64,131.07 for 2nd half 2017 + \$53,442.50 for Jan - May 2018

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

Facility Name & ID Number Heartland of Peoria

0049379 Report Period Beginning:

06/01/17 Ending:

05/31/18

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).

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1984, 1998, 2001 & 2002	\$ 236,851	1
2			2004	42,897	2
3	TOTALS			\$ 279,748	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104			1963	\$ 834,425	\$ 65,820		\$ 65,820	\$	\$ 2,887,362	4
5	20			1992	1,191,466						5
6	10			1998	911,507						6
7	10			2002	913,140						7
8				2007	365,081						8
Improvement Type**											
9	Current Year Depreciation					91,916		91,916		3,583,192	9
10				1978	65,310						10
11				1979	23,480						11
12				1981	63,642						12
13				1982	10,239						13
14				1983	6,057						14
15				1984	9,737						15
16				1985	9,518						16
17				1987	65,867						17
18	RETIREMENTS			1987	(33,597)						18
19				1988	15,166						19
20				1989	176,034						20
21				1990	35,994						21
22				1991	125,588						22
23				1992	134,218						23
24	RETIREMENTS			1992	(18,859)						24
25				1993	29,944						25
26				1994	78,083						26
27				1995	97,515						27
28				1996	73,410						28
29				1997	64,638						29
30				1998	55,583						30
31				1999	40,160						31
32				2000	93,167						32
33				2001	532,524						33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Peoria

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Report Period Beginning:

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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	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	70

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

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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	Totals from Page 12A, Carried Forward		\$ 6,131,120	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	1
2	INSTALL CABINETS	2004	10,272						2
3	PAINTING AND WALLCOVERING	2004	7,200						3
4	VINYL WALL COVERING	2004	1,593						4
5	VINYL TILE AND VINYL WALL COVERING	2004	10,000						5
6	VINYL TILE AND VINYL WALL COVERING	2004	274						6
7	PAINTING AND WALLCOVERING	2005	800						7
8	VINYL WALL COVERING	2004	1,004						8
9	LABOR, PERMITS FOR REHAB ROOM RENOV	2004	2,650						9
10	PAINT DOORS, FRAMES, HEATERS	2004	5,800						10
11	NORSTAR PHONE SYSTEM	2005	18,681						11
12	CUSTOM CABINETS	2005	11,770						12
13	ARCH & ENGINEERING COST	2005	665						13
14	ARCH & ENGINEERING COST	2005	456						14
15	ARCH & ENGINEERING COST	2005	3,585						15
16	CARPET	2005	5,524						16
17	PLUMBING FOR KITCHEN	2004	2,440						17
18	ELECTRICAL FOR KITCHEN	2004	1,975						18
19	FIRE DOOR	2005	4,706						19
20	CARPET	2005	3,060						20
21	CARPET	2005	1,087						21
22	WATER LINES	2005	27,419						22
23	PLUMBING	2005	3,047						23
24	ARCHITECTURAL DRAWINGS	2005	5,623						24
25	WALLCOVERING	2005	1,337						25
26	FIVE HOLLOW METAL DOORS/FRAMES	2006	8,370						26
27	HOLLOW METAL DOOR	2006	1,431						27
28	CARPETING/WALLCOVERING	2006	9,473						28
29	CARPENTRY FOR HALL/OFFICE/LOBBY REN	2006	85,850						29
30	ELECTRICAL FOR FIRE ALARM	2006	3,472						30
31	FRAME, DRYWALL	2006	3,900						31
32	OVERHEAD & INTEREST	2006	6,737						32
33	FIRE SPRINKLER SYSTEM	2006	124,976						33
34	TOTAL (lines 1 thru 33)		\$ 6,506,297	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	34

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

Facility Name & ID Number Heartland of Peoria

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Report Period Beginning:

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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	Totals from Page 12B, Carried Forward		\$ 6,506,297	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	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	TOTAL (lines 1 thru 33)		\$ 7,254,050	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	34

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

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Report Period Beginning:

06/01/17

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	
1	Totals from Page 12C, Carried Forward		\$ 7,254,050	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	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	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	34

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

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Report Period Beginning:

06/01/17

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	
1	Totals from Page 12D, Carried Forward		\$ 7,891,741	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	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	Paint Breakroom	2014	2,565						15
16	Ceiling in Gand Heritage office	2014	1,485						16
17	Painting Room 508	2014	1,433						17
18	Kitchen drain	2014	4,747						18
19	WALLCOVERING	2014	6,324						19
20	Paint in dining room	2014	7,965						20
21	Paint Arcadia Hall & A/L Dining	2014	11,580						21
22	Paint Resident Rooms 516-17 & 519-20	2014	10,364						22
23	Paint Resident Rooms 516-17 & 519-21	2014	26,842						23
24	Paint Laundry Room	2014	4,485						24
25	Paint -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	TOTAL (lines 1 thru 33)		\$ 8,185,364	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	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:

06/01/17

Ending:

05/31/18

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	Totals from Page 12E, Carried Forward		\$ 8,185,364	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	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	Fire system-replace monitor modules	2016	3,226						6
7	Repair/Replace Wall & Floor Tile in 100 hall shower room	2016	2,520						7
8	Repair floor expansion joint & VCT in Dining room	2016	2,856						8
9	New Concrete & caulk minor cracks in Center Courtyard	2016	4,278						9
10	Re-feed Electrical circuits to 6 pt rooms in Arcadia Unit	2016	9,834						10
11	Repaired leak in water service to building	2017	6,635						11
12	Replace dry pipe valve in the fire sprinkler valve closet in basemen	2017	6,350						12
13									13
14	Repipe water from RPZ to branch lines-mech room	2017	25,371						14
15	Repair water main leak-parking lot	2017	8,283						15
16	Vinyl flooring for Grand Heritage dining room	2017	7,046						16
17	Replace dishwasher exhaust fan	2017	2,850						17
18	Rooftop Unit 5T	2017	10,530						18
19	Carpet & frt in 100 hallway, conf room and several offices	2017	4,471						19
20	PLUMBING material for main hallway	2017	4,500						20
21	Repair water main and fill ditch in front parking lot	2018	7,931						21
22	Repair boiler line behind cooler	2018	2,887						22
23	landscape & Install new brick border-courtyard	2017	4,950						23
24	Water heater in 100 hall	2018	6,550						24
25	AC in Dietary Office	2018	6,875						25
26	Exhaust sys for 4 bathrooms in Arcadia Hall & 2 bathrooms in 100	2018	11,950						26
27	Concrete drain repair in parking lot	2018	2,882						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,346,206	\$ 157,736		\$ 157,736	\$	\$ 6,470,554	34

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

Facility Name & ID Number Heartland of Peoria

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Report Period Beginning:

06/01/17

Ending:

05/31/18

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	\$ 2,484,757	\$ 59,374	\$ 59,374	\$		\$ 2,361,493	71
72	Current Year Purchases	112,281						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			15,139	15,139			74
75	TOTALS	\$ 2,597,038	\$ 59,374	\$ 74,513	\$ 15,139		\$ 2,361,493	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)	\$ 11,222,992	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 217,110	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,249	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,139	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,832,047	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Heartland of Peoria

0049379

Report Period Beginning: 06/01/17

Ending: 05/31/18

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.	/2019	\$	
13.	/2020	\$	
14.	/2021	\$	

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: \$ 42,546

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 Van 5 + 2	\$	20,557	17
18					18
19				above figure includes	19
20				gas & maintenance too	20
21	TOTAL		\$	20,557	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	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	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	3234	hrs	\$ 137,561		\$	872	3,234	\$ 138,433	1
2	Licensed Speech and Language Development Therapist	10a	1595	hrs	67,836			846	1,595	68,682	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4266	hrs	181,475			9,311	4,266	190,786	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				348,688		348,688	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3				21	1,278	1,278	21	2,556	12
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3					68,464	32,386		100,850	13
14	TOTAL				\$ 386,872	21	\$ 69,742	\$ 393,381	9,116	\$ 849,995	14

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

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 700	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>594,174</u>)	1,204,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,257		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,223,460	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	279,748		13
14	Buildings, at Historical Cost	8,346,206		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,597,038		16
17	Accumulated Depreciation (book methods)	(8,832,047)		17
18	Deferred Charges	161,978		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>	151,720		22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,704,643	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,928,103	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 215,230	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	474,456		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,574		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accounts Payable</u>	149,476		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 956,736	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,887,254		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)	\$ 1,887,254	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,843,990	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,084,113	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,928,103	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,502,027	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,502,027	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,764,073)	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)	\$ (4,764,073)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	4,346,159	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 4,346,159	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,084,113	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Peoria

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Report Period Beginning: 06/01/17

Ending:

05/31/18

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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,934,046	1
2	Discounts and Allowances for all Levels	(4,407,739)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,526,307	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,218,732	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,218,732	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,274	12
13	Barber and Beauty Care	5,236	13
14	Non-Patient Meals	25	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	691,465	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	127,886	19
20	Radiology and X-Ray	25,140	20
21	Other Medical Services	56,255	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 907,281	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount & QI Payments	372	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 372	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,652,692	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,270,901	31
32	Health Care	4,803,944	32
33	General Administration	3,815,780	33
B. Capital Expense			
34	Ownership	2,790,673	34
C. Ancillary Expense			
35	Special Cost Centers	488,890	35
36	Provider Participation Fee	246,577	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,416,765	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,764,073)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,764,073)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,730,765	44
45	Private Pay - Net Inpatient Revenue	854,389	45
46	Medicare - Net Inpatient Revenue	241,826	46
47	Other-(specify) <u>Hospice</u>	330,296	47
48	Other-(specify) <u>Insurance</u>	369,031	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,526,307	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.

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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	1,891	2,071	\$ 105,616	\$ 51.00	1
2	Assistant Director of Nursing	5,738	6,284	211,052	33.59	2
3	Registered Nurses	17,154	18,786	608,817	32.41	3
4	Licensed Practical Nurses	31,862	34,893	879,953	25.22	4
5	CNAs & Orderlies	85,477	93,937	1,288,232	13.71	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,319	13,493	573,976	42.54	7
8	Rehab/Therapy Aides	13,618	14,916	456,682	30.62	8
9	Activity Director	5,976	6,554	97,284	14.84	9
10	Activity Assistants					10
11	Social Service Workers	5,725	6,282	153,624	24.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,281	20,050	253,357	12.64	15
16	Dishwashers					16
17	Maintenance Workers	2,545	2,773	77,320	27.88	17
18	Housekeepers	14,147	15,522	187,159	12.06	18
19	Laundry	3,884	4,261	40,980	9.62	19
20	Administrator	2,080	2,080	119,048	57.23	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,996	14,274	389,419	27.28	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	1,872	2,054	35,796	17.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	2,212	2,425	33,473	13.80	33
34	TOTAL (lines 1 - 33)	237,777	260,655	\$ 5,511,788 *	\$ 21.15	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	28,600	9, 3	36
37	Medical Records Consultant				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)		\$ 28,600		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$	10, 3	50	
51	Licensed Practical Nurses	127	4,553	10, 3	51
52	Certified Nurse Assistants/Aides		10, 3	52	
53	TOTAL (lines 50 - 52)	127	\$ 4,553		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 \$4,297 & AHCA \$2,113
- (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. \$ 60,620 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. \$ 246,577
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 25
- (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