

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041178

Facility Name: Riverview, A Sr. Lvg Community

Address: 500 Centennial Drive East Peoria 61611
 Number City Zip Code

County: Tazwell

Telephone Number: (309) 694-0022 **Fax #** (309) 694-3655

HFS ID Number: 520886946023

Date of Initial License for Current Owners: 10/03/95

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/05 to 05/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
	(Title) <u>Vice President - Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Riverview, A Sr. Lvg Community# 0041178 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 06/01/05

	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	<u>61</u>	Skilled (SNF)	<u>67</u>	<u>24,455</u>	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	<u>61</u>	TOTALS	<u>67</u>	<u>24,455</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>350</u>	<u>9,237</u>	<u>13,453</u>	<u>23,040</u>	8
9	SNF/PED					9
10	ICF	<u>50</u>			<u>50</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>400</u>	<u>9,237</u>	<u>13,453</u>	<u>23,090</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.42%

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

10 (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/AF. 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 10/03/95

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

YES Date 10/03/95 NO

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

YES NO If YES, enter number of beds certified 67 and days of care provided 8,853Medicare Intermediary HighMark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 05/31/06

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

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	310,796	(2)	3,422	314,216	2,071	316,287	316,287			1
2	Food Purchase		32,713		32,713		32,713	(1,266)	31,447		2
3	Housekeeping	93,839	9,220	132	103,191		103,191		103,191		3
4	Laundry	32,291	14,872		47,163		47,163		47,163		4
5	Heat and Other Utilities			167,870	167,870	4,191	172,061	(2,629)	169,432		5
6	Maintenance	38,451	10,751	29,081	78,283		78,283		78,283		6
7	Other (specify):* Medical Waste			1,738	1,738		1,738		1,738		7
8	TOTAL General Services	475,377	67,554	202,243	745,174	6,262	751,436	(3,895)	747,541		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	1,429,868	124,063	87,410	1,641,341	7,518	1,648,859	(3,105)	1,645,754		10
10a	Therapy		4,692	736,517	741,209		741,209		741,209		10a
11	Activities	45,185	1,470	1,717	48,372		48,372		48,372		11
12	Social Services	101,854	254	1,656	103,764		103,764		103,764		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,576,907	130,479	831,300	2,538,686	7,518	2,546,204	(3,105)	2,543,099		16
	C. General Administration										
17	Administrative	73,509		252,157	325,666	(56,842)	268,824		268,824		17
18	Directors Fees										18
19	Professional Services			7,408	7,408	(352)	7,056	(7,056)			19
20	Dues, Fees, Subscriptions & Promotions			29,119	29,119		29,119	(17,993)	11,126		20
21	Clerical & General Office Expenses	96,292	33,844	89,861	219,997	352	220,349	(73,586)	146,763		21
22	Employee Benefits & Payroll Taxes			455,484	455,484	31,234	486,718		486,718		22
23	Inservice Training & Education			588	588		588		588		23
24	Travel and Seminar			8,273	8,273		8,273		8,273		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,857	71,857		71,857		71,857		26
27	Other (specify):*										27
28	TOTAL General Administration	169,801	33,844	914,747	1,118,392	(25,608)	1,092,784	(98,635)	994,149		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,222,085	231,877	1,948,290	4,402,252	(11,828)	4,390,424	(105,635)	4,284,789		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 Riverview, A Sr. Lvg Community #0041178 Report Period Beginning: 06/01/05 Ending: 05/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			270,514	270,514	11,828	282,342		282,342			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			62,498	62,498		62,498	19,350	81,848			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			75,921	75,921		75,921		75,921			35
36	Other (specify):*											36
37	TOTAL Ownership			408,933	408,933	11,828	420,761	19,350	440,111			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		342,197	39,403	381,600		381,600		381,600			39
40	Barber and Beauty Shops		(554)	26,338	25,784		25,784		25,784			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,737	36,737		36,737		36,737			42
43	Other (specify):* IV Therapy Drugs		40,179		40,179		40,179		40,179			43
44	TOTAL Special Cost Centers		381,822	102,478	484,300		484,300		484,300			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,222,085	613,699	2,459,701	5,295,485		5,295,485	(86,285)	5,209,200			45

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

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,266)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,629)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	4,921	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(944)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,275)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,056)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,316)	21		24
25	Fund Raising, Advertising and Promotional	(17,993)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	19,350	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,077)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (86,285)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,285)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Riverview, A Sr. Lvg Community

ID# 0041178

Report Period Beginning: 06/01/05

Ending: 05/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Customer Reimbursement	\$ (916)	21 1
2	Transportation Revenue	(2,161)	10 2
3			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	(3,077)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,266)	0	0	0	0	0	0	0	0	0	0	(1,266)	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	(2,629)	0	0	0	0	0	0	0	0	0	0	(2,629)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,895)	0	0	0	0	0	0	0	0	0	0	(3,895)	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	(3,105)	0	0	0	0	0	0	0	0	0	0	(3,105)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,105)	0	0	0	0	0	0	0	0	0	0	(3,105)	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	(7,056)	0	0	0	0	0	0	0	0	0	0	(7,056)	19
20	Fees, Subscriptions & Promotions	(17,993)	0	0	0	0	0	0	0	0	0	0	(17,993)	20
21	Clerical & General Office Expenses	(73,586)	0	0	0	0	0	0	0	0	0	0	(73,586)	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	(98,635)	0	0	0	0	0	0	0	0	0	0	(98,635)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,635)	0	0	0	0	0	0	0	0	0	0	(105,635)	29

STATE OF ILLINOIS

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05 Ending:

Summary B

05/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	19,350	0	0	0	0	0	0	0	0	0	0	19,350	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	19,350	0	19,350	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(86,285)	0	(86,285)	45									

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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 (See H.O. Cost Report)	Toledo, OH			

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	\$ 252,157	HCR ManorCare, Inc	100.00%	\$ 252,157	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Mangement	13,082	Heartland Management Services	100.00%	13,082	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 265,239			\$ 265,239	\$ *

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

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 Riverview, A Sr. Lvg Community

0041178

Report Period Beginning: 06/01/05

Ending: 05/31/06

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 St
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5494

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	2,501,870,392	369 Nurs Fac	\$ 1,107,111	\$ 591,572	4,679,797	\$ 2,071	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			4,679,797	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		4,679,797	501	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		4,679,797	3,690	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	4,679,797	1,443	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	4,679,797	6,075	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	4,679,797	46,373	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	4,679,797	148,943	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		4,679,797	11,903	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,355		4,679,797	19,330	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			4,679,797	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		4,679,797	11,828	12
13										13
14	32	Interest				7,118,315				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,039	\$ 69,154,917		\$ 252,157	25

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 45,016	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.)		\$ 64,366	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 19,350	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 62,498	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.		\$ 81,848	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	57,167	8
	2002	59,634	9
	2003	63,899	10
	2004	64,396	11
	2005	62,498	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Riverview, A Sr. Lvg Community COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0041178

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 2005 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 2005.

(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>04-04-25-100-013</u>	<u>See Attached (16%)</u>	<u>\$ 7,985.99</u>	<u>\$ 1,277.76</u>
2. <u>01-01-23-200-025</u>	<u>See Attached (16%)</u>	<u>\$ 187,321.20</u>	<u>\$ 29,971.39</u>
3. <u>04-04-25-100-013</u>	<u>See Attached (16%)</u>	<u>\$ 7,985.99</u>	<u>\$ 1,277.76</u>
4. <u>01-01-23-200-025</u>	<u>See Attached (16%)</u>	<u>\$ 187,321.20</u>	<u>\$ 29,971.39</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 390,614.38	\$ 62,498.30

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? X YES NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Riverview, A Sr. Lvg Community

0041178 Report Period Beginning:

06/01/05 Ending:

05/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,311 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).

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	<u>Facility</u>		<u>1995</u>	<u>\$ 335,515</u>	1
2					2
3	TOTALS			\$ 335,515	3

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59			1995	\$ 2,170,148	\$ 56,787		\$ 56,787		\$ 193,286	4
5		CR 5/31/99 Audit Adj		2002	(802,552)						5
6	2			2003	345,836						6
7	6			2006	525,467						7
8											8
		Improvement Type**									
9		BUILDING IMPROVEMENTS (Current Year Depreciation)				145,172		145,172		531,145	9
10		CR 5/31/99 AUDIT ADJ		1990	2,279						10
11		CR 5/31/99 AUDIT ADJ		1993	10,497						11
12		CR 5/31/99 AUDIT ADJ		1994	975						12
13		CR 5/31/99 AUDIT ADJ		1994	3,509						13
14		CR 5/31/99 AUDIT ADJ		1995	3,969						14
15		FLOORING/CARPETING		1997	2,228						15
16		ELECTRICAL		1997	4,089						16
17		KICKPLATES		1997	2,838						17
18		HOT WATER TANK		1997	2,744						18
19		FLOORING		1997	1,825						19
20		MOTOR		1997	2,305						20
21		GAZEBO IMPROVEMENTS		1997	1,737						21
22		WALL COVERING		1997	5,337						22
23		ROOM UPGRADES		1997	37,321						23
24		SIGNS		1997	1,179						24
25		STEAMER		1997	2,587						25
26		ROOFING		1998	1,117						26
27		FLOORING		1998	4,963						27
28		CARPENTRY		1998	3,150						28
29		PLUMBING		1998	10,659						29
30		WALLCOVERING		1998	9,932						30
31		DOOR/WINDOW		1998	658						31
32		RENOVATION-PATIENT ROOMS		1998	41,798						32
33		FINISH /STUD		1998	4,351						33
34		CARPENTRY		1998	4,953						34
35		DOOR/WINDOW		1998	14,573						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 Riverview, A Sr. Lvg Community# 0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOORING	1998	\$ 6,859	\$		\$	\$	\$	37
38	PLUMBING	1998	757						38
39	ELECTRICAL	1998	7,844						39
40	PAINTING/WALLCOVERING	1998	12,790						40
41	PAINTING/WALLCOVERING	1998	11,007						41
42	ROOFING	1998	500						42
43	SIGNAGE	1998	28,202						43
44	HVAC	1998	4,530						44
45	CONCRETE SIDEWALK	1998	1,800						45
46	PAINTING/WALLCOVERING	1999	460						46
47	DINING ROOM REMODEL	1999	3,196						47
48	WALLCOVERING	2000	47						48
49	WALLCOVERING	2000	148						49
50	WALLCOVERING	2000	417						50
51	DOUBLE EGRESS DOORS	2000	2,985						51
52	JOCKEY PUMP FOR SPRINKER SYSTEM	2000	310						52
53	OFFICE REMODELING	2000	660						53
54	DINING RENOVATIONS	2000	2,169						54
55	OFFICE RENO	2000	3,064						55
56	CIRCULATING PUMP & PIPING	2000	2,814						56
57	DINING ROOM REMODELING COST	2000	540						57
58	WALLCOVERING	2000	1,689						58
59	PIPING	2000	998						59
60	PIPING COST	2000	22						60
61	ADDTL PIPING COST	2000	274						61
62	PIPING COST	2000	2,475						62
63	PIPING	2000	33,529						63
64	ADDTL COST OFFICE RENOVATION	2000	231						64
65	COUNTERTOP-OFFICE RENOVATION	2000	795						65
66	SPRINKLER WORK	2000	963						66
67	SPRINKLER WORK - RETAINAGE	2000	107						67
68	WALLCOVERING-BUSINESS OFFICES	2000	2,000						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,554,654	\$ 201,959		\$ 201,959	\$	\$ 724,431	70

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

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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		\$ 2,554,654	\$ 201,959		\$ 201,959	\$	\$ 724,431	1
2	<u>BORDER - DON OFFICE</u>	2000	30						2
3	<u>WALLCOVERING</u>	2000	95						3
4	<u>CONSULTANT-DINING RM</u>	2000	3,514						4
5	<u>FLOORING-DINING RM</u>	2000	1,091						5
6	<u>FLOORING-DINING RM</u>	2000	70						6
7	<u>WALLCOVERING-DINING RM</u>	2000	573						7
8	<u>DINING RM RENOVATIONS</u>	2000	1,540						8
9	<u>WALLCOVERING</u>	2000	344						9
10	<u>DINING RM DEMO</u>	2000	400						10
11	<u>CONSULTING-OFFICE RENOV</u>	2000	543						11
12	<u>JOHNSON CONTROL COMPRESSOR</u>	2000	1,189						12
13	<u>ELECTRICAL</u>	2000	3,951						13
14	<u>ELECTRICAL-RETAINAGE</u>	2000	439						14
15	<u>PTAC UNITS & DUCKWORK-OFFICE</u>	2000	16,375						15
16	<u>DUCTWORK & WALLS-OFFICES</u>	2000	1,819						16
17	<u>CARPET</u>	2000	4,652						17
18	<u>CARPET</u>	2000	200						18
19	<u>ADDT'L DINING ROOM RENOVATION</u>	2000	162						19
20	<u>ELECTRICAL</u>	2000	1,919						20
21	<u>ELECTRICAL</u>	2000	960						21
22	<u>ADDT'L COSTS OF ROOFTOP</u>	2001	226						22
23	<u>CEILING-TILES LAUNDRY ROOM</u>	2001	1,855						23
24	<u>CEILING TILE</u>	2001	4,985						24
25	<u>TILE CEILING</u>	2001	1,599						25
26	<u>CUSTOM NURSES STATION</u>	2001	8,469						26
27	<u>CEILING TILE</u>	2001	2,350						27
28	<u>VINYL FLOOR COVERING WITH BASE</u>	2001	1,300						28
29	<u>RELOCATE EXHAUST FANS & GRILLE</u>	2001	4,478						29
30	<u>RELOCATE EXHAUST FANS & GRILLE</u>	2001	498						30
31	<u>PAINTING</u>	2001	2,900						31
32	<u>LANDSCAPING</u>	2001	7,097						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,630,274	\$ 201,959		\$ 201,959	\$	\$ 724,431	34

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

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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		\$ 2,630,274	\$ 201,959		\$ 201,959	\$	\$ 724,431	1
2	FIRE CAULKING AND SAFING	2002	3,886						2
3	BORDER	2002	75						3
4	DRYVIT FOR WINDOWS	2002	7,700						4
5	BORDER	2002	101						5
6	WINDOW TREATMENTS	2002	1,670						6
7	WALLCOVERING AND PAINTING	2002	171						7
8	CARPET	2002	3,542						8
9	WALLCOVERING, PAINTING	2002	1,537						9
10	VINYL WALL COVERING	2002	312						10
11	VINYL WALL COVERING	2002	276						11
12	CARPET	2003	298						12
13	VINYL WALL COVERING	2003	2,536						13
14	VINYL WALL COVERING AND BORDER	2003	858						14
15	VINYL WALL COVERING	2003	6,014						15
16	GENERAL CONTRACTING FEES	2003	73,912						16
17	ADDITIONAL COST METAL DOOR	2003	1,087						17
18	VINYL WALL COVERING AND BORDER	2003	10,700						18
19	FLOORING	2003	570						19
20	FREIGHT ON WALL COVERING	2003	105						20
21	FREIGHT ON WALL COVERING	2003	258						21
22	ADDITIONAL CONTRATOR FEES	2003	427						22
23	METAL DOOR	2003	9,782						23
24	ARCHITECT & ENGINEER COSTS	2003	52,481						24
25	GENERAL OVERHEAD	2003	169,901						25
26	INTEREST ON CONSTRUCTION	2003	19,685						26
27	CARPET AND PAD	2003	11,635						27
28	FREIGHT ON CARPET	2003	64						28
29	FREIGHT ON ARTWORK	2003	244						29
30	FLOORING	2003	10,500						30
31	CONCRETE TESTING	2003	2,407						31
32	GENERAL CONTRACTOR	2003	44,443						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,067,450	\$ 201,959		\$ 201,959	\$	\$ 724,431	34

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

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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		\$ 3,067,450	\$ 201,959		\$ 201,959	\$	\$ 724,431	1
2	CONCRETE	2003	3,800						2
3	STEEL GUARDRAIL	2004	3,680						3
4	PATIO COVER	2004	13,695						4
5	PATIO COVER - ADDTL COSTS	2004	1,500						5
6	FREIGHT ON VINYL WALL COVERING	2004	255						6
7	PARKING LOT	2005	10,900						7
8	GENERAL CONTRACTOR	2005	29,379						8
9	SOIL TESTING	2005	2,262						9
10	CONCRETE TESTING	2005	1,005						10
11	SITE PREPARATION	2005	15,633						11
12	AUTOMATIC DOOR CONTROL	2005	2,056						12
13	ARCHITECT & ENGINEER COSTS	2005	60,748						13
14	ARCHITECT & ENGINEER COSTS	2005	8,132						14
15	ENGINEER COSTS - CIVIL	2005	4,200						15
16	ENGINEER COSTS	2005	563						16
17	OVERHEAD	2005	27,918						17
18	PERMIT FEES	2005	7,424						18
19	PLAN REVIEWS	2005	2,490						19
20	INTEREST	2005	13,848						20
21	MILLWORK	2005	2,047						21
22	CARPETING & PADS	2005	985						22
23	WALL COVERING	2005	5,853						23
24	CORNER PADS	2005	369						24
25	OVERHEAD	2005	540						25
26	INTEREST	2005	166						26
27	WALL COVERING	2005	12,298						27
28	CORNER GUARDS	2005	1,092						28
29	CARPENTRY	2005	31,325						29
30	VINYL WALL COVERING	2006	5,530						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,337,142	\$ 201,959		\$ 201,959	\$	\$ 724,431	34

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

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	\$ 1,017,501	\$ 68,555	\$ 68,555	\$		\$ 795,075	71
72	Current Year Purchases	134,143						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,828	11,828			74
75	TOTALS	\$ 1,151,644	\$ 68,555	\$ 80,383	\$ 11,828		\$ 795,075	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)	\$	4,824,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	270,514	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	282,342	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	11,828	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,519,506	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	CIP	\$ 196,382	92
93			93
94			94
95		\$ 196,382	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 Riverview, A Sr. Lvg Community

0041178

Report Period Beginning: 06/01/05

Ending: 05/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 75,921

Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect 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	<u>N/A</u>		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	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		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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$	6,386	\$ 291,025	\$ 232	6,386	\$ 291,257	1	
2	Licensed Speech and Language Development Therapist	10a	hrs		1,109	50,545		1,109	50,545	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a	hrs		8,649	394,122	4,460	8,649	398,582	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39	# of prescrpts				342,197		342,197	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify): P/S-Lab, X-Ray	10, Col 3, 39				40,228			40,228	13	
14	TOTAL			\$	16,144	\$ 775,920	\$ 346,889	16,144	\$ 1,122,809	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 Riverview, A Sr. Lvg Community# 0041178Report Period Beginning: 06/01/05Ending: 05/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (9,866)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (163,888))	1,137,824		3
4	Supply Inventory (priced at)	13,854		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,614		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,143,426	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	335,515		13
14	Buildings, at Historical Cost	3,337,142		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,151,644		16
17	Accumulated Depreciation (book methods)	(1,519,506)		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>	196,382		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,501,177	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,644,603	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,667	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,532		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,747		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	105,446		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 356,392	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 356,392	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,288,211	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,644,603	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,417,210	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,417,210	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	733,770	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)	\$ 733,770	17
	B. Transfers (Itemize):		
18	Change in Interdivision	137,231	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 137,231	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,288,211	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Riverview, A Sr. Lvg Community

0041178

Report Period Beginning: 06/01/05

Ending: 05/31/06

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	\$ 4,333,598	1
2	Discounts and Allowances for all Levels	(508,093)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,825,505	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,815,998	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,815,998	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		12
13	Barber and Beauty Care	17,026	13
14	Non-Patient Meals	1,266	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	336,700	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,332	19
20	Radiology and X-Ray	10,267	20
21	Other Medical Services	2,161	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 387,752	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,029,255	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	745,174	31
32	Health Care	2,538,686	32
33	General Administration	1,118,392	33
B. Capital Expense			
34	Ownership	408,933	34
C. Ancillary Expense			
35	Special Cost Centers	484,300	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)*	\$ 5,295,485	40
41	Income before Income Taxes (line 30 minus line 40)**	733,770	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 733,770	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 Riverview, A Sr. Lvg Community

0041178

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	1,950	2,119	\$ 60,797	\$ 28.69	1
2	Assistant Director of Nursing	2,500	2,717	69,049	25.41	2
3	Registered Nurses	4,263	4,632	116,159	25.08	3
4	Licensed Practical Nurses	27,066	29,413	627,669	21.34	4
5	CNAs & Orderlies	43,380	47,142	530,362	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,980	4,325	45,185	10.45	10
11	Social Service Workers	5,928	6,390	101,854	15.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,234	36,234	310,796	8.58	15
16	Dishwashers					16
17	Maintenance Workers	3,047	3,307	38,451	11.63	17
18	Housekeepers	8,949	9,726	93,839	9.65	18
19	Laundry	3,291	3,575	32,291	9.03	19
20	Administrator	2,352	2,352	73,509	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,236	7,156	96,292	13.46	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	2,329	2,529	25,832	10.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,505	161,617	\$ 2,222,085 *	\$ 13.75	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	4,000	Ln 9,Col 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)		\$ 4,000		49

C. CONTRACT NURSES

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

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 \$ 3,444
- (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 \$ 1,102
- (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. \$ 30,349 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. \$ 36,737
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. \$ (1,266)
- (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? _____
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.