

Facility Name & ID Number Heartland of Riverview

0049486 Report Period Beginning: 6/1/08 Ending: 5/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>67</u>	Skilled (SNF)	<u>71</u>	<u>25,303</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>67</u>	TOTALS	<u>71</u>	<u>25,303</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>120</u>	<u>6,912</u>	<u>15,702</u>	<u>22,734</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>120</u>	<u>6,912</u>	<u>15,702</u>	<u>22,734</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.85%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 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 _____ and days of care provided 12,057

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 6/1/08 Ending: 5/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	203,519			203,519	1,807	205,326		205,326		1
2	Food Purchase		131,478		131,478		131,478	(636)	130,842		2
3	Housekeeping	109,864	15,317	9,761	134,942		134,942		134,942		3
4	Laundry	32,417	16,491	3,888	52,796		52,796		52,796		4
5	Heat and Other Utilities			134,852	134,852	3,427	138,279	(1,952)	136,327		5
6	Maintenance	66,520	15,738	48,893	131,151		131,151		131,151		6
7	Other (specify):* Med Waste			470	470		470		470		7
8	TOTAL General Services	412,320	179,024	197,864	789,208	5,234	794,442	(2,588)	791,854		8
	B. Health Care and Programs										
9	Medical Director			5,974	5,974		5,974		5,974		9
10	Nursing and Medical Records	1,557,912	183,368	146,172	1,887,452	2,898	1,890,350	(19,202)	1,871,148		10
10a	Therapy	859,010	12,071	67,671	938,752		938,752		938,752		10a
11	Activities	46,392	1,297	1,557	49,246		49,246		49,246		11
12	Social Services	117,579	307		117,886		117,886		117,886		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,580,893	197,043	221,374	2,999,310	2,898	3,002,208	(19,202)	2,983,006		16
	C. General Administration										
17	Administrative	81,108		252,648	333,756	(47,874)	285,882		285,882		17
18	Directors Fees										18
19	Professional Services			3,854	3,854		3,854	(3,854)			19
20	Dues, Fees, Subscriptions & Promotions			54,262	54,262		54,262	(30,893)	23,369		20
21	Clerical & General Office Expenses	162,664	32,892	131,825	327,381		327,381	(92,144)	235,237		21
22	Employee Benefits & Payroll Taxes			535,682	535,682	30,387	566,069		566,069		22
23	Inservice Training & Education			1,719	1,719		1,719		1,719		23
24	Travel and Seminar			7,525	7,525		7,525		7,525		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			103,543	103,543		103,543		103,543		26
27	Other (specify):*										27
28	TOTAL General Administration	243,772	32,892	1,091,058	1,367,722	(17,487)	1,350,235	(126,891)	1,223,344		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,236,985	408,959	1,510,296	5,156,240	(9,355)	5,146,885	(148,681)	4,998,204		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

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			260,982	260,982	9,355	270,337		270,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(267)	(267)		(267)		(267)			32
33	Real Estate Taxes			69,804	69,804		69,804	2,340	72,144			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			121,474	121,474		121,474		121,474			35
36	Other (specify):*											36
37	TOTAL Ownership			451,993	451,993	9,355	461,348	2,340	463,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,437	2,437		2,437	(2,437)				38
39	Ancillary Service Centers		415,588		415,588		415,588		415,588			39
40	Barber and Beauty Shops			24,147	24,147		24,147		24,147			40
41	Coffee and Gift Shops	41,732			41,732		41,732		41,732			41
42	Provider Participation Fee			38,326	38,326		38,326		38,326			42
43	Other (specify):*		65,087	91,860	156,947		156,947		156,947			43
44	TOTAL Special Cost Centers	41,732	480,675	156,770	679,177		679,177	(2,437)	676,740			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,278,717	889,634	2,119,059	6,287,410		6,287,410	(148,778)	6,138,632			45

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (29)	21	1
2	Ambulance Expense	(2,437)	38	2
3	Transportation Expense	(19,202)	10	3
4	Accrued for RE Taxes paid 6/09 that should have			4
5	been paid in C/R year	34,902	33	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	13,234		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Riverview# 0049486

Report Period Beginning:

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(636)	0	0	0	0	0	0	0	0	0	0	(636)	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	(1,952)	0	0	0	0	0	0	0	0	0	0	(1,952)	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	(2,588)	0	(2,588)	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	(19,202)	0	0	0	0	0	0	0	0	0	0	(19,202)	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	(19,202)	0	(19,202)	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	(3,854)	0	0	0	0	0	0	0	0	0	0	(3,854)	19
20	Fees, Subscriptions & Promotions	(30,893)	0	0	0	0	0	0	0	0	0	0	(30,893)	20
21	Clerical & General Office Expenses	(92,144)	0	0	0	0	0	0	0	0	0	0	(92,144)	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	(126,891)	0	(126,891)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(148,681)	0	(148,681)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Riverview# 0049486

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	2,340	0	0	0	0	0	0	0	0	0	0	2,340	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,340	0	0	0	0	0	0	0	0	0	0	2,340	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(2,437)	0	0	0	0	0	0	0	0	0	0	(2,437)	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	(2,437)	0	0	0	0	0	0	0	0	0	0	(2,437)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(148,778)	0	0	0	0	0	0	0	0	0	0	(148,778)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	\$ 252,648	HCR ManorCare, Inc.	100.00%	\$ 252,648	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	30,934	Heartland Management Services	100.00%	30,934		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 283,582			\$ 283,582	\$ *	14

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

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac	\$ 1,686	\$ 5,342,885	\$ 3	1	
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	1,103,816	559,529	5,342,885	1,804	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac	287,502		5,342,885	557	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	1,755,769		5,342,885	2,870	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac			5,342,885	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	1,773,058	1,106,606	5,342,885	2,898	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac	30,646,209	36,538,442	5,342,885	59,341	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	88,964,011	51,489,483	5,342,885	145,433	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac	6,188,752		5,342,885	11,984	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	11,257,416		5,342,885	18,403	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs Fac			5,342,885	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs Fac	5,722,441		5,342,885	9,355	12
13										13
14	32	Interest								14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 147,700,660	\$ 89,694,060		\$ 252,648	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Conv Sub Debentures		X	N/A															
2	National City Bank, Trustee																		
3																			
4																			
5								Interest Income	(267)										
Working Capital																			
6																			
7																			
8																			
9	TOTAL Facility Related					\$	\$		(267)										
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related					\$	\$												
15	TOTALS (line 9+line14)					\$	\$		(267)										

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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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,898 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>1995</u>	<u>\$ 335,515</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 335,515</u>	<u>3</u>

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Ending:

5/31/09

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	59		1995	\$ 2,170,148	\$ 83,272		\$ 83,272	\$	\$ 422,457
5	CR 5/31/99 Audit Adj		2002	(802,552)					
6	2 (2003) & 6 (2005)		2003	871,303					
7	7/1/06 CAPITAL RATE ADJ #1		2005	29,379					
8	4		2008	707,879					
Improvement Type**									
9	BUILDING IMPROVEMENTS (Current Year Depreciation)		1990	2,279	112,054		112,054		828,638
10	CR 5/31/99 AUDIT ADJ		1993	10,497					
11	CR 5/31/99 AUDIT ADJ		1994	975					
12	CR 5/31/99 AUDIT ADJ		1994	3,509					
13	CR 5/31/99 AUDIT ADJ		1995	3,969					
14	CR 5/31/99 AUDIT ADJ		1997	2,228					
15	FLOORING/CARPETING		1997	4,089					
16	ELECTRICAL		1997	2,838					
17	KICKPLATES		1997	2,744					
18	HOT WATER TANK		1997	1,825					
19	FLOORING		1997	2,305					
20	MOTOR		1997	1,737					
21	GAZEBO IMPROVEMENTS		1997	5,337					
22	WALL COVERING		1997	37,321					
23	ROOM UPGRADES		1997	1,179					
24	SIGNS		1997	2,587					
25	STEAMER		1998	1,117					
26	ROOFING		1998	4,963					
27	FLOORING		1998	3,150					
28	CARPENTRY		1998	10,659					
29	PLUMBING		1998	9,932					
30	WALLCOVERING		1998	658					
31	DOOR/WINDOW		1998	41,798					
32	RENOVATION-PATIENT ROOMS		1998	4,351					
33	FINISH /STUD		1998	4,953					
34	CARPENTRY		1998	14,573					
35	DOOR/WINDOW								
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 Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	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)		\$ 3,291,912	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	70

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,291,912	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	1
2	BORDER - DON OFFICE	2000	30						2
3	WALLCOVERING	2000	95						3
4	CONSULTANT-DINING RM	2000	3,514						4
5	FLOORING-DINING RM	2000	1,091						5
6	FLOORING-DINING RM	2000	70						6
7	WALLCOVERING-DINING RM	2000	573						7
8	DINING RM RENOVATIONS	2000	1,540						8
9	WALLCOVERING	2000	344						9
10	DINING RM DEMO	2000	400						10
11	CONSULTING-OFFICE RENOV	2000	543						11
12	JOHNSON CONTROL COMPRESSOR	2000	1,189						12
13	ELECTRICAL	2000	3,951						13
14	ELECTRICAL-RETAINAGE	2000	439						14
15	PTAC UNITS & DUCKWORK-OFFICE	2000	16,375						15
16	DUCTWORK & WALLS-OFFICES	2000	1,819						16
17	CARPET	2000	4,652						17
18	CARPET	2000	200						18
19	ADDT'L DINING ROOM RENOVATION	2000	162						19
20	ELECTRICAL	2000	1,919						20
21	ELECTRICAL	2000	960						21
22	ADDT'L COSTS OF ROOFTOP	2001	226						22
23	CEILING-TILES LAUNDRY ROOM	2001	1,855						23
24	CEILING TILE	2001	4,985						24
25	TILE CEILING	2001	1,599						25
26	CUSTOM NURSES STATION	2001	8,469						26
27	CEILING TILE	2001	2,350						27
28	VINYL FLOOR COVERING WITH BASE	2001	1,300						28
29	RELOCATE EXHAUST FANS & GRILLE	2001	4,478						29
30	RELOCATE EXHAUST FANS & GRILLE	2001	498						30
31	PAINTING	2001	2,900						31
32	LANDSCAPING	2001	7,097						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,367,532	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	34

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,367,532	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	1
2	<u>FIRE CAULKING AND SAFING</u>	2002	3,886						2
3	<u>BORDER</u>	2002	75						3
4	<u>DRYVIT FOR WINDOWS</u>	2002	7,700						4
5	<u>BORDER</u>	2002	101						5
6	<u>WINDOW TREATMENTS</u>	2002	1,670						6
7	<u>WALLCOVERING AND PAINTING</u>	2002	171						7
8	<u>CARPET</u>	2002	3,542						8
9	<u>WALLCOVERING, PAINTING</u>	2002	1,537						9
10	<u>VINYL WALL COVERING</u>	2002	312						10
11	<u>VINYL WALL COVERING</u>	2002	276						11
12	<u>CARPET</u>	2003	298						12
13	<u>VINYL WALL COVERING</u>	2003	2,536						13
14	<u>VINYL WALL COVERING AND BORDER</u>	2003	858						14
15	<u>VINYL WALL COVERING</u>	2003	6,014						15
16	<u>GENERAL CONTRACTING FEES</u>	2003	73,912						16
17	<u>ADDITIONAL COST METAL DOOR</u>	2003	1,087						17
18	<u>VINYL WALL COVERING AND BORDER</u>	2003	10,700						18
19	<u>FLOORING</u>	2003	570						19
20	<u>FREIGHT ON WALL COVERING</u>	2003	105						20
21	<u>FREIGHT ON WALL COVERING</u>	2003	258						21
22	<u>ADDITIONAL CONTRATOR FEES</u>	2003	427						22
23	<u>METAL DOOR</u>	2003	9,782						23
24	<u>ARCHITECT & ENGINEER COSTS</u>	2003	52,481						24
25	<u>GENERAL OVERHEAD</u>	2003	169,901						25
26	<u>7/1/06 CAPITAL RATE ADJ #2</u>	2003	(169,901)						26
27	<u>INTEREST ON CONSTRUCTION</u>	2003	19,685						27
28	<u>7/1/06 CAPITAL RATE ADJ #3</u>	2003	(19,685)						28
29	<u>CARPET AND PAD</u>	2003	11,635						29
30	<u>FREIGHT ON CARPET</u>	2003	64						30
31	<u>7/1/06 CAPITAL RATE ADJ #4</u>	2003	(64)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,557,464	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	34

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,557,464	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	1
2	<u>FREIGHT ON ARTWORK</u>	2003	244						2
3	<u>7/1/06 CAPITAL RATE ADJ #5</u>	2003	(244)						3
4	<u>FLOORING</u>	2003	10,500						4
5	<u>CONCRETE TESTING</u>	2003	2,407						5
6	<u>GENERAL CONTRACTOR</u>	2003	44,443						6
7	<u>CONCRETE</u>	2003	3,800						7
8	<u>STEEL GUARDRAIL</u>	2004	3,680						8
9	<u>PATIO COVER</u>	2004	13,695						9
10	<u>PATIO COVER - ADDTL COSTS</u>	2004	1,500						10
11	<u>FREIGHT ON VINYL WALL COVERING</u>	2004	255						11
12	<u>PARKING LOT</u>	2005	10,900						12
13	<u>GENERAL CONTRACTOR</u>	2005	29,379						13
14	<u>7/1/06 CAPITAL RATE ADJ #12</u>	2005	(29,379)						14
15	<u>SOIL TESTING</u>	2005	2,262						15
16	<u>CONCRETE TESTING</u>	2005	1,005						16
17	<u>7/1/06 CAPITAL RATE ADJ #13</u>	2005	(1,005)						17
18	<u>SITE PREPARATION</u>	2005	15,633						18
19	<u>AUTOMATIC DOOR CONTROL</u>	2005	2,056						19
20	<u>ARCHITECT & ENGINEER COSTS</u>	2005	60,748						20
21	<u>ARCHITECT & ENGINEER COSTS</u>	2005	8,132						21
22	<u>ENGINEER COSTS - CIVIL</u>	2005	4,200						22
23	<u>ENGINEER COSTS</u>	2005	563						23
24	<u>7/1/06 CAPITAL RATE ADJ #6</u>	2005	(563)						24
25	<u>OVERHEAD</u>	2005	27,918						25
26	<u>7/1/06 CAPITAL RATE ADJ #7</u>	2005	(27,918)						26
27	<u>PERMIT FEES</u>	2005	7,424						27
28	<u>PLAN REVIEWS</u>	2005	2,490						28
29	<u>7/1/06 CAPITAL RATE ADJ #8</u>	2005	(2,490)						29
30	<u>INTEREST</u>	2005	13,848						30
31	<u>7/1/06 CAPITAL RATE ADJ #9</u>	2005	(13,848)						31
32	<u>MILLWORK</u>	2005	2,047						32
33	<u>CARPETING & PADS</u>	2005	985						33
34	TOTAL (lines 1 thru 33)		\$ 3,752,131	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	34

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,752,131	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	1
2	WALL COVERING	2005	5,853						2
3	CORNER PADS	2005	369						3
4	OVERHEAD	2005	540						4
5	7/1/06 CAPITAL RATE ADJ #10	2005	(540)						5
6	INTEREST	2005	166						6
7	7/1/06 CAPITAL RATE ADJ #11	2005	(166)						7
8	WALL COVERING	2005	12,298						8
9	CORNER GUARDS	2005	1,092						9
10	CARPENTRY	2005	31,325						10
11	VINYL WALL COVERING	2005	5,530						11
12	0107 OFFIC, LOCKER RM REN	2008	2,955						12
13	0107 OFFIC, LOCKER RM REN	2008	44,873						13
14	0107 OFFIC, LOCKER RM REN	2008	3,240						14
15	ADJ RIVERVIEW2 BUILDING ADDN	2008	(869)						15
16	00000000668 PT, LAND IMP - SITE PREP	2008	149,036						16
17	00000000669 PT, LAND IMP - DEVELOPER FEES	2008	43,606						17
18	00000000656 ALUMINUM ENTRY SYSTEM	2008	20,091						18
19	00000000657 DOOR OPENERS	2008	1,150						19
20	00000000665 0208 CORRIDOR WALL	2008	13,217						20
21	00000000666 PT - BLDIM ARCH & ENG COSTS	2008	110,092						21
22	00000000666 PT - BLDIM DEVELOPER O/H COSTS	2008	339,331						22
23	00000000666 PT - INTEREST	2008	47,691						23
24	00000000667 PT - WALLCOVERING	2008	9,406						24
25	00000000678 0208 CORRIDOR WALL	2008	23,670						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,616,087	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,616,087	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	1
2								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	TOTAL (lines 1 thru 33)	\$ 4,616,087	\$ 195,326		\$ 195,326	\$	\$ 1,251,095	34

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

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	\$ 1,183,848	\$ 65,656	\$ 65,656	\$		\$ 992,558	71
72	Current Year Purchases	101,454						72
73	Fully Depreciated Assets							73
74	Home Office			9,355	9,355			74
75	TOTALS	\$ 1,285,302	\$ 65,656	\$ 75,011	\$ 9,355		\$ 992,558	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)	\$ 6,236,904	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 260,982	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 270,337	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,355	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,243,653	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 121,474 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Bed., Etc

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	9942 hrs	\$ 373,231	1,561	\$ 39,019	\$ 572	11,503	\$ 412,822	1
2	Licensed Speech and Language Development Therapist	10a	2547 hrs	95,629	122	3,060	7	2,669	98,696	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	10393 hrs	390,150	1,024	25,592	11,492	11,417	427,234	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	5,39,2	# of prescrpts				415,588		415,588	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>P/S X-Ray & Lab</u>	5,43,2				91,860			91,860	13
14	TOTAL			\$ 859,010	2,707	\$ 159,531	\$ 427,659	25,589	\$ 1,446,200	14

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning: 6/1/08

Ending: 5/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5/31/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 29,349	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,095,409		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,172		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,126,930	\$	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	4,616,089		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,285,300		16
17	Accumulated Depreciation (book methods)	(2,243,653)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,993,251	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,120,181	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 77,754	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,978		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,706		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Acc Payables</u>	(23,823)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 388,615	\$	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)	\$ 388,615	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,731,566	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,120,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,046,978	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,046,978	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,827,545	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)	\$ 1,827,545	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,142,957)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,142,957)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,731,566	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Riverview# 0049486Report Period Beginning: 6/1/08Ending: 5/31/09

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	\$ 5,973,717	1
2	Discounts and Allowances for all Levels	(1,002,087)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,971,630	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,471,805	6
7	Oxygen	81,071	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,552,876	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	12,667	13
14	Non-Patient Meals	636	14
15	Telephone, Television and Radio	23	15
16	Rental of Facility Space		16
17	Sale of Drugs	455,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,289	19
20	Radiology and X-Ray	49,033	20
21	Other Medical Services	28,370	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 590,420	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	<u>Miscellaneous</u>	29	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,114,955	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	789,208	31
32	Health Care	2,999,310	32
33	General Administration	1,367,722	33
B. Capital Expense			
34	Ownership	451,993	34
C. Ancillary Expense			
35	Special Cost Centers	679,177	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)*	\$ 6,287,410	40
41	Income before Income Taxes (line 30 minus line 40)**	1,827,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,827,545	43

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

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

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

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

6/1/08

Ending:

5/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,156	2,333	\$ 80,852	\$ 34.66	1
2	Assistant Director of Nursing	6,208	6,717	181,950	27.09	2
3	Registered Nurses	6,399	6,923	176,827	25.54	3
4	Licensed Practical Nurses	25,233	27,301	593,699	21.75	4
5	CNAs & Orderlies	40,295	43,707	502,910	11.51	5
6	CNA Trainees					6
7	Licensed Therapist	11,241	12,165	456,678	37.54	7
8	Rehab/Therapy Aides	14,747	15,959	402,332	25.21	8
9	Activity Director					9
10	Activity Assistants	3,949	4,282	46,392	10.83	10
11	Social Service Workers	5,951	6,438	117,579	18.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,178	21,178	203,519	9.61	15
16	Dishwashers					16
17	Maintenance Workers	3,560	3,864	66,520	17.22	17
18	Housekeepers	9,357	10,134	109,864	10.84	18
19	Laundry	3,400	3,683	32,417	8.80	19
20	Administrator	2,080	2,080	81,108	38.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,952	12,090	162,664	13.45	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	1,922	2,089	21,674	10.38	31
32	Other Health Care(specify)					32
33	Other(specify)	3,591	3,899	41,732	10.70	33
34	TOTAL (lines 1 - 33)	172,219	184,842	\$ 3,278,717 *	\$ 17.74	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	5,974	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,290	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	8,264		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 \$2834.53
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,230 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. \$ 38,326
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. \$ 636
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.