

Facility Name & ID Number Heartland of Riverview

0049486 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	71	Skilled (SNF)	71	25,915	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	71	TOTALS	71	25,915	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	12	5,668	17,642	23,322	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12	5,668	17,642	23,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.99%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 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 71 and days of care provided 11,130

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 Fiscal Year: 05/31

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	202,027			202,027	6,658	208,685		208,685		1
2	Food Purchase		135,651		135,651		135,651	(424)	135,227		2
3	Housekeeping	87,222	11,609	297	99,128		99,128		99,128		3
4	Laundry	37,159	17,895	3,337	58,391		58,391		58,391		4
5	Heat and Other Utilities			83,482	83,482	1,853	85,335		85,335		5
6	Maintenance	55,848	14,689	72,064	142,601		142,601		142,601		6
7	Other (specify):* Medical Waste			102	102		102		102		7
8	TOTAL General Services	382,256	179,844	159,282	721,382	8,511	729,893	(424)	729,469		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	1,756,610	218,460	365,547	2,340,617	2,445	2,343,062		2,343,062		10
10a	Therapy	1,025,283	11,439	12,492	1,049,214		1,049,214		1,049,214		10a
11	Activities	47,350	1,306	325	48,981		48,981		48,981		11
12	Social Services	117,981	165		118,146		118,146		118,146		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,947,224	231,370	385,364	3,563,958	2,445	3,566,403		3,566,403		16
	C. General Administration										
17	Administrative	85,878		316,255	402,133	(81,011)	321,122		321,122		17
18	Directors Fees										18
19	Professional Services			2,553	2,553		2,553	(2,553)			19
20	Dues, Fees, Subscriptions & Promotions			75,895	75,895		75,895	(53,918)	21,977		20
21	Clerical & General Office Expenses	148,323	30,387	148,778	327,488		327,488	(112,520)	214,968		21
22	Employee Benefits & Payroll Taxes			600,045	600,045	55,275	655,320		655,320		22
23	Inservice Training & Education			3,282	3,282		3,282		3,282		23
24	Travel and Seminar			6,035	6,035		6,035		6,035		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			173,671	173,671		173,671		173,671		26
27	Other (specify):*										27
28	TOTAL General Administration	234,201	30,387	1,326,514	1,591,102	(25,736)	1,565,366	(168,991)	1,396,375		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,563,681	441,601	1,871,160	5,876,442	(14,780)	5,861,662	(169,415)	5,692,247		29

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

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

Facility Name & ID Number Heartland of Riverview

#0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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			319,954	319,954	14,780	334,734		334,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			66,667	66,667		66,667		66,667			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			119,030	119,030		119,030		119,030			35
36	Other (specify):*											36
37	TOTAL Ownership			505,651	505,651	14,780	520,431		520,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			25,069	25,069		25,069		25,069			38
39	Ancillary Service Centers		457,844		457,844		457,844		457,844			39
40	Barber and Beauty Shops			11,250	11,250		11,250		11,250			40
41	Coffee and Gift Shops	57,315			57,315		57,315		57,315			41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* IV X-Ray & Lab		44,475	69,296	113,771		113,771		113,771			43
44	TOTAL Special Cost Centers	57,315	502,319	144,488	704,122		704,122		704,122			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,620,996	943,920	2,521,299	7,086,215		7,086,215	(169,415)	6,916,800			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(424)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(163)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions	(20)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,553)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(111,681)	21		24
25	Fund Raising, Advertising and Promotional	(53,918)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,415)		\$	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))	\$ (169,415)		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						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

Heartland of Riverview

ID# 0049486

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ 0	21	1
2	Misc. Income	0	21	2
3	Activity Income	0	11	3
4	Loss on Disposal of Fixed Assets	0	36	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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Riverview# 0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(424)	0	0	0	0	0	0	0	0	0	0	(424)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(424)	0	(424)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,553)	0	0	0	0	0	0	0	0	0	0	(2,553)	19
20	Fees, Subscriptions & Promotions	(53,918)	0	0	0	0	0	0	0	0	0	0	(53,918)	20
21	Clerical & General Office Expenses	(112,520)	0	0	0	0	0	0	0	0	0	0	(112,520)	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	(168,991)	0	(168,991)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(169,415)	0	(169,415)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Riverview# 0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(169,415)	0	0	0	0	0	0	0	0	0	0	(169,415)	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
HCR Manor Care, Inc.	100	Health Care & Retirement Corporation of America (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						
2	V	Page						
3	V	8						
4	V							
5	V							
6	V	10a						
		Therapy Management	29,622	Heartland Rehab Services, LLC	100.00%	29,622		
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 345,877			\$ 345,877	\$ *	

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

Facility Name & ID Number

Heartland of Riverview

#

0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

06/01/09

Ending: 05/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

HCR Manor Care, Inc.

Street Address

333 North Summit St.

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	\$ 2,826,629	\$ 1,585,087	6,731,127	\$ 6,658	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	6,731,127	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	0	0	6,731,127	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	0	0	6,731,127	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	6,731,127	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	911,333	0	6,731,127	1,853	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	6,731,127	1,490	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	6,731,127	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	469,810	0	6,731,127	955	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	35,518,981	0	6,731,127	83,661	10
11	17	General & Admin - Direct to Cent	Accumulated Cost	691,284,298	95NFs	1,045,204	0	6,731,127	10,177	11
12	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	69,554,530	79,745,671	6,731,127	141,406	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	6,239,311	0	6,731,127	14,696	13
14	22	Employee Benefits - Direct to Cent	Accumulated Cost	691,284,298	95NFs	2,434,366	0	6,731,127	23,704	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	8,300,418	0	6,731,127	16,875	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714	0	6,731,127	242	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95NFs	43,612	0	6,731,127	425	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	6,941,685	0	6,731,127	14,113	18
19										19
20	32	Directly Assigned Interest				21,122,019			0	20
21		Non Central Division Nursing Home Allocation				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 316,255	25

Facility Name & ID Number

Heartland of Riverview

0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		8	9	10									
					Name of Lender	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						\$	\$			\$	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2009 report.		\$	104,706		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.)		\$	105,652		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	946		3																			
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	65,721		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.		\$	66,667		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<u>62,498</u>	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2009	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2006	<u>66,198</u>	9																					
	2007	<u>65,125</u>	10																					
	2008	<u>69,804</u>	11																					
	2009	<u>71,696</u>	12																					
Line 2: \$105,652 = \$34,902 for 1st half of 2008 paid in June '09 + \$34,902 for 2nd half of 2008 paid in Sept. '09 + \$35,848 for 1st half of 2009 paid in May '10.																								
Line 4: \$65,721 = \$35,848 2nd half 2009 + \$29,873 estimate for Jan-May 2010.																								

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Riverview COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0049486

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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</u>	\$ <u>17,422.70</u>	\$ <u>2,787.63</u>
2.	<u>01-01-23-200-025</u>	<u>See Attached</u>	\$ <u>430,674.28</u>	\$ <u>68,907.88</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u>Real estate tax bills are split between two business units within the building.</u>		\$ <u> </u>	\$ <u> </u>
5.	<u>16% to Heartland of Riverview SNF. Column (D).</u>		\$ <u> </u>	\$ <u> </u>
6.	<u>84% to Riverview Senior Living Community</u>		\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u>448,096.98</u>	\$ <u>71,695.52</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heartland of Riverview

0049486 Report Period Beginning:

06/01/09 Ending:

05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,083 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 90,646		\$ 90,646	\$	\$ 513,103	4
5	CR 5/31/99 Audit Adj		2002	(802,552)						5
6	2 (2003) & 6 (2005)		2003	871,303						6
7	7/1/06 CAPITAL RATE ADJ #1		2005	29,379						7
8	4		2008	707,879						8
Improvement Type**										
9	Current Year Depreciation				158,924		158,924		987,562	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 Heartland of Riverview

0049486

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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:

06/01/09

Ending:

05/31/10

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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	1
2	BORDER - DON OFFICE	2000	30						2
3	WALLCOVERING	2000	95						3
4	CONSULTANT-DINING RM	2000	3,513						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	161						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	4,477						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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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:

06/01/09

Ending:

05/31/10

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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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	73,911						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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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:

06/01/09

Ending:

05/31/10

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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	1
2	FREIGHT ON ARTWORK	2003	244						2
3	7/1/06 CAPITAL RATE ADJ #5	2003	(244)						3
4	FLOORING	2003	10,500						4
5	CONCRETE TESTING	2003	2,407						5
6	GENERAL CONTRACTOR	2003	44,443						6
7	CONCRETE	2003	3,800						7
8	STEEL GUARDRAIL	2004	3,680						8
9	PATIO COVER	2004	13,695						9
10	PATIO COVER - ADDTL COSTS	2004	1,500						10
11	FREIGHT ON VINYL WALL COVERING	2004	255						11
12	PARKING LOT	2005	10,900						12
13	GENERAL CONTRACTOR	2005	29,379						13
14	7/1/06 CAPITAL RATE ADJ #12	2005	(29,379)						14
15	SOIL TESTING	2005	2,262						15
16	CONCRETE TESTING	2005	1,005						16
17	7/1/06 CAPITAL RATE ADJ #13	2005	(1,005)						17
18	SITE PREPARATION	2005	15,633						18
19	AUTOMATIC DOOR CONTROL	2005	2,056						19
20	ARCHITECT & ENGINEER COSTS	2005	60,748						20
21	ARCHITECT & ENGINEER COSTS	2005	8,132						21
22	ENGINEER COSTS - CIVIL	2005	4,200						22
23	ENGINEER COSTS	2005	563						23
24	7/1/06 CAPITAL RATE ADJ #6	2005	(563)						24
25	OVERHEAD	2005	27,918						25
26	7/1/06 CAPITAL RATE ADJ #7	2005	(27,918)						26
27	PERMIT FEES	2005	7,424						27
28	PLAN REVIEWS	2005	2,490						28
29	7/1/06 CAPITAL RATE ADJ #8	2005	(2,490)						29
30	INTEREST	2005	13,848						30
31	7/1/06 CAPITAL RATE ADJ #9	2005	(13,848)						31
32	MILLWORK	2005	2,047						32
33	CARPETING & PADS	2005	985						33
34	TOTAL (lines 1 thru 33)		\$ 3,752,131	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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:

06/01/09

Ending:

05/31/10

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	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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	Replace Concrete	2009	9,950						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,626,037	\$ 249,570		\$ 249,570	\$	\$ 1,500,665	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	\$ 1,285,302	\$ 70,384	\$ 70,384	\$		\$ 1,062,942	71
72	Current Year Purchases	29,902						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			14,780	14,780			74
75	TOTALS	\$ 1,315,204	\$ 70,384	\$ 85,164	\$ 14,780		\$ 1,062,942	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)	\$ 6,276,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 334,734	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,780	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,563,607	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:				\$ _____			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: \$ 91,261 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		\$ _____	\$ <u>27,769</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>27,769</u>	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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, 1	6339 hrs	\$ 242,361		\$	451	6,339	\$ 242,812	1
2	Licensed Speech and Language Development Therapist	10a, 1	2284 hrs	87,332			1	2,284	87,333	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	6795 hrs	259,783			10,981	6,795	270,764	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				457,844		457,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>IV Theray</u>	43, 2					44,475		44,475	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					69,296		69,296	13
14	TOTAL			\$ 589,476		\$ 69,296	\$ 513,752	15,418	\$ 1,172,524	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: 06/01/09

Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10

(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	\$ (3,786)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>236,523</u>)	1,386,188		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)	\$ 1,384,574	\$	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	4,626,039		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,315,202		16
17	Accumulated Depreciation (book methods)	(2,563,607)		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>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,713,149	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,097,723	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 102,074	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	249,373		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,721		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	18,991		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 436,159	\$	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)	\$ 436,159	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,661,564	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,097,723	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,731,566	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,731,566	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,092,821	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,092,821	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(2,162,823)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,162,823)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,661,564	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland of Riverview# 0049486Report Period Beginning: 06/01/09Ending: 05/31/10

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	\$ 9,266,907	1
2	Discounts and Allowances for all Levels	(3,848,867)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,418,040	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,981,416	6
7	Oxygen	1,239	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,982,655	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	6,845	13
14	Non-Patient Meals	424	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	493,133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	173,240	19
20	Radiology and X-Ray	58,952	20
21	Other Medical Services	45,727	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 778,321	23
D. Non-Operating Revenue			
24	Contributions	20	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts		28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,179,036	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	721,382	31
32	Health Care	3,563,958	32
33	General Administration	1,591,102	33
B. Capital Expense			
34	Ownership	505,651	34
C. Ancillary Expense			
35	Special Cost Centers	665,249	35
36	Provider Participation Fee	38,873	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,086,215	40
41	Income before Income Taxes (line 30 minus line 40)**	2,092,821	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,092,821	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:

06/01/09

Ending:

05/31/10

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	2,056	2,246	\$ 77,815	\$ 34.65	1
2	Assistant Director of Nursing	3,796	4,146	113,296	27.33	2
3	Registered Nurses	12,532	13,689	346,036	25.28	3
4	Licensed Practical Nurses	24,234	26,470	589,631	22.28	4
5	CNAs & Orderlies	48,604	53,257	607,571	11.41	5
6	CNA Trainees					6
7	Licensed Therapist	15,418	16,716	639,129	38.23	7
8	Rehab/Therapy Aides	14,034	15,216	386,154	25.38	8
9	Activity Director	3,872	4,243	47,350	11.16	9
10	Activity Assistants					10
11	Social Service Workers	5,962	6,495	117,981	18.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,333	20,667	202,027	9.78	15
16	Dishwashers					16
17	Maintenance Workers	2,861	3,135	55,848	17.81	17
18	Housekeepers	7,385	8,094	87,222	10.78	18
19	Laundry	3,762	4,123	37,159	9.01	19
20	Administrator	2,080	2,080	85,878	41.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,890	9,950	148,323	14.91	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	1,898	2,080	22,261	10.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	4,750	5,207	57,315	11.01	33
34	TOTAL (lines 1 - 33)	177,467	197,814	\$ 3,620,996 *	\$ 18.31	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	7,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,329	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)	\$	8,329		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

Facility Name & ID Number Heartland of Riverview

0049486

Report Period Beginning: 06/01/09

Ending: 05/31/10

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 \$2594
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,143 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. \$ 38,873
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. \$ 424
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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? No
Attach invoices and a summary of services for all architect and appraisal fees.