FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0049486

Facility Name: Heartland of Riverview

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

County: Tazewell

Telephone Number: (309) 694-9865 **Fax #** (309) 699-2192

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski **Telephone Number:** (419) 252-5736
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/15 to 05/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Martin D. Allen
(Title) Director

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,986	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	25,986	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,203	4,060	14,195	20,458	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,203	4,060	14,195	20,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.73%

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)
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 [X]

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

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 [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 8,517

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,851	299	6,589	157,739		157,739		157,739			1
2	Food Purchase		129,828		129,828		129,828	(5,899)	123,929			2
3	Housekeeping	51,804	14,870	617	67,291		67,291		67,291			3
4	Laundry	40,993	7,630		48,623		48,623		48,623			4
5	Heat and Other Utilities			135,245	135,245	1,482	136,727		136,727			5
6	Maintenance	37,588	11,846	58,445	107,879		107,879		107,879			6
7	Other (specify):* Med Waste			203	203		203		203			7
8	TOTAL General Services	281,236	164,473	201,099	646,808	1,482	648,290	(5,899)	642,391			8
	B. Health Care and Programs											
9	Medical Director			18,589	18,589		18,589		18,589			9
10	Nursing and Medical Records	1,712,044	173,089	89,388	1,974,521	4,973	1,979,494		1,979,494			10
10a	Therapy	1,033,547	10,267	27,272	1,071,086		1,071,086		1,071,086			10a
11	Activities	50,799	144	1,807	52,750		52,750		52,750			11
12	Social Services	153,602			153,602		153,602		153,602			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,949,992	183,500	137,056	3,270,548	4,973	3,275,521		3,275,521			16
	C. General Administration											
17	Administrative	96,557		251,580	348,137	(87,727)	260,410		260,410			17
18	Directors Fees											18
19	Professional Services			40,863	40,863		40,863	(40,863)				19
20	Dues, Fees, Subscriptions & Promotions			81,052	81,052		81,052	(33,369)	47,683			20
21	Clerical & General Office Expenses	215,062	33,989	295,168	544,219		544,219	(213,511)	330,708			21
22	Employee Benefits & Payroll Taxes			526,800	526,800	22,291	549,091		549,091			22
23	Inservice Training & Education			2,280	2,280		2,280		2,280			23
24	Travel and Seminar			17,874	17,874		17,874		17,874			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			598,633	598,633		598,633		598,633			26
27	Other (specify):*											27
28	TOTAL General Administration	311,619	33,989	1,814,250	2,159,858	(65,436)	2,094,422	(287,743)	1,806,679			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,542,847	381,962	2,152,405	6,077,214	(58,981)	6,018,233	(293,642)	5,724,591			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: 06/01/15 Ending: 05/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			193,751	193,751	7,590	201,341		201,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163,089	163,089	51,391	214,480	(163,759)	50,721			32
33	Real Estate Taxes			80,825	80,825		80,825		80,825			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			78,322	78,322		78,322		78,322			35
36	Other (specify):*											36
37	**TOTAL Ownership**			515,987	515,987	58,981	574,968	(163,759)	411,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		433,205		433,205		433,205		433,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	29,163			29,163		29,163		29,163			41
42	Provider Participation Fee			110,861	110,861		110,861		110,861			42
43	Other (specify):* IV | X-Ray & Lab		38,982	94,523	133,505		133,505		133,505			43
44	**TOTAL Special Cost Centers**	29,163	472,187	205,384	706,734		706,734		706,734			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,572,010	854,149	2,873,776	7,299,935		7,299,935	(457,401)	6,842,534			45

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,899)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(85)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(128)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,529)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,920)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(211,769)	21		24
25	Fund Raising, Advertising and Promotional	(33,369)	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	(171,702)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (457,401)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (457,401)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heartland of Riverview

ID# 0049486

Report Period Beginning: 06/01/15

Ending: 05/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income		21	3
4	Donations Revenue		21	4
5	Accouning/Collection Fees	(7,943)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(163,759)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(171,702)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Riverview **#** 0049486 **Report Period Beginning:** 06/01/15 **Ending:** 05/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,899)	0	0	0	0	0	0	0	0	0	0	(5,899)	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**	(5,899)	0	0	0	0	0	0	0	0	0	0	(5,899)	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	(40,863)	0	0	0	0	0	0	0	0	0	0	(40,863)	19
20	Fees, Subscriptions & Promotions	(33,369)	0	0	0	0	0	0	0	0	0	0	(33,369)	20
21	Clerical & General Office Expenses	(213,511)	0	0	0	0	0	0	0	0	0	0	(213,511)	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**	(287,743)	0	0	0	0	0	0	0	0	0	0	(287,743)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(293,642)	0	0	0	0	0	0	0	0	0	0	(293,642)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Riverview # 0049486 **Report Period Beginning:** 06/01/15 **Ending:** 05/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(163,759)	0	0	0	0	0	0	0	0	0	0	(163,759)	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**	(163,759)	0	0	0	0	0	0	0	0	0	0	(163,759)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(457,401)	0	0	0	0	0	0	0	0	0	0	(457,401)	45

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 251,580	HCR Manor Care Services, LLC	100.00%	$ 251,580	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,572,010	Heartland Employment Services, LLC	100.00%	3,572,010		4
5	V	10a	Therapy Management	8,236	Heartland Rehabilitation Services, LLC	100.00%	8,236		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,831,826			$ 3,831,826	$ *	14

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 06/01/15 Ending: 05/31/16

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 [X] NO [ ]

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

Name of Related Organization: HCR Manor Care Services LLC
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, &	$ 818,127	$	7,107,579	$ 1,482	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs			7,107,579	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			7,107,579	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	7,107,579	570	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	7,107,579	4,403	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			7,107,579	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	7,107,579	109,145	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	7,107,579	29,763	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		7,107,579	24,945	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		7,107,579	9,428	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		7,107,579	12,863	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			7,107,579	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		7,107,579	6,148	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		7,107,579	1,442	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			7,107,579	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		7,107,579	51,391	22
23	32	Directly Assigned Interest	Not Allocated			18,868,647				23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797				24
25	TOTALS					$ 177,277,351	$ 35,285,370		$ 251,580	25

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	
	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	Pooled Interest										51,391	7
8	Interest Expense / Interest Income										(670)	8
9	TOTAL Facility Related						$	$			$ 50,721	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 50,721	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.)**

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 72,825	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.)		$ 79,933	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,107	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,718	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.		$ 80,825	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	72,548	8
	2012	79,423	9
	2013	79,916	10
	2014	79,446	11
	2015	80,419	12

Line 2: $79,932.74 = $39,723.01 for 2nd half 2014 + $40,209.73 for 1st half 2015

Line 4: $73,718.08= $40,209.75 for 2nd half 2015 + $33,508.33 for Jan - May 2016

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Riverview COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0049486

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-25-100-013	See Attached	$ 18,042.66	$ 2,886.83
2.	01-01-14-400-021	See Attached	$ 331.00	$ 52.96
3.	01-01-23-200-025	See Attached	$ 484,248.08	$ 77,479.69
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 502,621.74	$ 80,419.48

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 06/01/15 Ending: 05/31/16

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. [X] (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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 335,515	1
2					2
3	TOTALS			$ 335,515	3

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59			1995	$ 2,170,148	$ 81,287		$ 81,287	$	$ 1,017,400	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					62,541		62,541		1,683,013	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											15
16	Consolidated 1997			1997	64,190						16
17	Consolidated 1998			1998	170,443						17
18	Consolidated 1999			1999	3,656						18
19	Consolidated 2000			2000	96,101						19
20	Consolidated 2001			2001	35,756						20
21	Consolidated 2002			2002	19,270						21
22											22
23	CARPET			2003	298						23
24	VINYL WALL COVERING			2003	2,536						24
25	VINYL WALL COVERING AND BORDER			2003	858						25
26	VINYL WALL COVERING			2003	6,014						26
27	GENERAL CONTRACTING FEES			2003	73,911						27
28	ADDITIONAL COST METAL DOOR			2003	1,087						28
29	VINYL WALL COVERING AND BORDER			2003	10,700						29
30	FLOORING			2003	570						30
31	FREIGHT ON WALL COVERING			2003	105						31
32	FREIGHT ON WALL COVERING			2003	258						32
33	ADDITIONAL CONTRATOR FEES			2003	427						33
34	METAL DOOR			2003	9,782						34
35	ARCHITECT & ENGINEER COSTS			2003	52,481						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: 06/01/15 Ending: 05/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GENERAL OVERHEAD	2003	$ 169,901	$		$	$	$	37
38	7/1/06 CAPITAL RATE ADJ #2	2003	(169,901)						38
39	INTEREST ON CONSTRUCTION	2003	19,685						39
40	7/1/06 CAPITAL RATE ADJ #3	2003	(19,685)						40
41	CARPET AND PAD	2003	11,635						41
42	FREIGHT ON CARPET	2003	64						42
43	7/1/06 CAPITAL RATE ADJ #4	2003	(64)						43
44	FREIGHT ON ARTWORK	2003	244						44
45	7/1/06 CAPITAL RATE ADJ #5	2003	(244)						45
46	FLOORING	2003	10,500						46
47	CONCRETE TESTING	2003	2,407						47
48	GENERAL CONTRACTOR	2003	44,443						48
49	CONCRETE	2003	3,800						49
50	STEEL GUARDRAIL	2004	3,680						50
51	PATIO COVER	2004	13,695						51
52	PATIO COVER - ADDTL COSTS	2004	1,500						52
53	FREIGHT ON VINYL WALL COVERING	2004	255						53
54	PARKING LOT	2005	10,900						54
55	GENERAL CONTRACTOR	2005	29,379						55
56	7/1/06 CAPITAL RATE ADJ #12	2005	(29,379)						56
57	SOIL TESTING	2005	2,262						57
58	CONCRETE TESTING	2005	1,005						58
59	7/1/06 CAPITAL RATE ADJ #13	2005	(1,005)						59
60	SITE PREPARATION	2005	15,633						60
61	AUTOMATIC DOOR CONTROL	2005	2,056						61
62	ARCHITECT & ENGINEER COSTS	2005	60,748						62
63	ARCHITECT & ENGINEER COSTS	2005	8,132						63
64	ENGINEER COSTS - CIVIL	2005	4,200						64
65	ENGINEER COSTS	2005	563						65
66	7/1/06 CAPITAL RATE ADJ #6	2005	(563)						66
67	OVERHEAD	2005	27,918						67
68	7/1/06 CAPITAL RATE ADJ #7	2005	(27,918)						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,741,675	$ 143,828		$ 143,828	$	$ 2,700,413	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: 06/01/15 Ending: 05/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,741,675	$ 143,828		$ 143,828	$	$ 2,700,413	1
2	PERMIT FEES	2005	7,424						2
3	PLAN REVIEWS	2005	2,490						3
4	7/1/06 CAPITAL RATE ADJ #8	2005	(2,490)						4
5	INTEREST	2005	13,848						5
6	7/1/06 CAPITAL RATE ADJ #9	2005	(13,848)						6
7	MILLWORK	2005	2,047						7
8	CARPETING & PADS	2005	985						8
9	WALL COVERING	2005	5,853						9
10	CORNER PADS	2005	369						10
11	OVERHEAD	2005	540						11
12	7/1/06 CAPITAL RATE ADJ #10	2005	(540)						12
13	INTEREST	2005	166						13
14	7/1/06 CAPITAL RATE ADJ #11	2005	(166)						14
15	WALL COVERING	2005	12,298						15
16	CORNER GUARDS	2005	1,092						16
17	CARPENTRY	2005	31,325						17
18	VINYL WALL COVERING	2005	5,530						18
19									19
20	0107 OFFIC, LOCKER RM REN	2008	2,955						20
21	0107 OFFIC, LOCKER RM REN	2008	44,873						21
22	0107 OFFIC, LOCKER RM REN	2008	3,240						22
23	ADJ RIVERIVEW2 BUILDING ADDN	2008	(869)						23
24	000000000668 PT, LAND IMP - SITE PREP	2008	149,036						24
25	000000000669 PT, LAND IMP - DEVELOPER FEES	2008	43,606						25
26	000000000656 ALUMINUM ENTRY SYSTEM	2008	20,091						26
27	000000000657 DOOR OPENERS	2008	1,150						27
28	000000000665 0208 CORRIDOR WALL	2008	13,217						28
29	000000000666 PT - BLDIM ARCH & ENG COSTS	2008	110,092						29
30	000000000666 PT - BLDIM DEVELOPER O/H COSTS	2008	339,332						30
31	000000000666 PT - INTEREST	2008	47,691						31
32	000000000667 PT - WALLCOVERING	2008	9,406						32
33	000000000678 0208 CORRIDOR WALL	2008	23,670						33
34	TOTAL (lines 1 thru 33)		$ 4,616,088	$ 143,828		$ 143,828	$	$ 2,700,413	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: 06/01/15 Ending: 05/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,616,088	$ 143,828		$ 143,828	$	$ 2,700,413	1
2	Replace Concrete in 15 areas	2009	9,950						2
3									3
4	TV Direct System 24 Channel	2011	14,970						4
5	Repl drywall & paint Ext. wall (15 res. rms. #28-42 & dining rm.)	2011	49,600						5
6	Paint Activity Room	2011	3,269						6
7									7
8	Repl drywall & paint walls (6 res. Rms: 43-45 & 10-12 + dining rm	2012	54,278						8
9	Phone System	2012	2,537						9
10	A/C unit for telephone room	2012	5,850						10
11	Double Egress Door	2012	11,014						11
12	Drywall & Insulation, 12 res. rooms	2012	6,272						12
13	Drywall & Insulation, 16 rms & dining room	2012	63,624						13
14	Drywall & Insulation, PT/OT room	2012	24,237						14
15									15
16	Boilers (2) for Laundry & Kitchen	2013	21,375						16
17	Concrete pad for dumpster & approach	2013	6,537						17
18	Light fixture upgrade - whole building	2014	13,265						18
19	All 36 resident room bath flooring	2014	19,480						19
20	GEN ELEC UPGRADES	2014	9,500						20
21	consulting for new build	2014	1,350						21
22	1/2 Kit Floor Upgrades -5503 sq ft	2014	3,778						22
23	additional flooring for the 36 resident baths	2014	32,738						23
24	ceiling for 30 resident rooms	2015	7,523						24
25	to rework electrical to overloaded transformer. Run conduit from 480V .								25
26	to boiler room.	2015	11,655						26
27									27
28	repair/repl 3 nurses sta annuncs/dr alarms damaged by storm	2015	5,057						28
29	prime and paint both elevators	2015	3,280						29
30	ceiling tile repl in common areas of the facility	2015	3,850						30
31	skim walls, prime and paint room 19	2015	2,825						31
32	cut out walls in rm 203/ceiling in rm 103 to repair leaks in rm 303	2015	2,950						32
33	Life Safety Corr to generator located outside back hall.	2015	4,975						33
34	TOTAL (lines 1 thru 33)		$ 5,011,826	$ 143,828		$ 143,828	$	$ 2,700,413	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: 06/01/15 Ending: 05/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,559,244	$ 49,923	$ 49,923	$		$ 1,453,040	71
72	Current Year Purchases	11,257						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			7,590	7,590			74
75	TOTALS	$ 1,570,501	$ 49,923	$ 57,513	$ 7,590		$ 1,453,040	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,917,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,751	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,341	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,590	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,153,453	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 57,460 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		$	$ 20,862	17
18					18
19					19
20					20
21	TOTAL		$	$ 20,862	21

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3882 hrs	$ 161,192		$	$ 189	3,882	$ 161,381	1
2	Licensed Speech and Language Development Therapist	10a	1514 hrs	62,862			246	1,514	63,108	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4716 hrs	195,823			9,832	4,716	205,655	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 prescrpts				433,205		433,205	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhalation Therapist	10a, 3			470	26,772		470	26,772	12
13	Other (specify): IV Therapy/X-Ray/Lab	43, 2 & 3				94,523	38,982		133,505	13
14	TOTAL			$ 419,877	470	$ 121,295	$ 482,454	10,582	$ 1,023,626	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.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Riverview **#** 0049486 **Report Period Beginning:** 06/01/15 **Ending:** 05/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/16 **(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	$ 1,963	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (443,095))	1,119,283		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,597		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,123,843	$	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	5,011,826		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,570,501		16
17	Accumulated Depreciation (book methods)	(4,153,453)		17
18	Deferred Charges	131,995		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe OMIT	76,501		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,972,885	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,096,728	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,366	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	345,841		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,718		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	80,950		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 628,875	$	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)**	$ 628,875	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,467,853	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,096,728	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,456,169	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,456,169	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	417,028	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)**	$ 417,028	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(405,344)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (405,344)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,467,853	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,843,282	1
2	Discounts and Allowances for all Levels	(4,858,840)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,984,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,669,214	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,669,214	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	1,373	13
14	Non-Patient Meals	5,899	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	901,861	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,856	19
20	Radiology and X-Ray	36,343	20
21	Other Medical Services	44,890	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,063,222	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount	85	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 85	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,716,963	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	646,808	31
32	Health Care	3,270,548	32
33	General Administration	2,159,858	33
	B. Capital Expense		
34	Ownership	515,987	34
	C. Ancillary Expense		
35	Special Cost Centers	595,873	35
36	Provider Participation Fee	110,861	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,299,935	40
41	**Income before Income Taxes (line 30 minus line 40)****	417,028	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 417,028	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 317,882	44
45	Private Pay - Net Inpatient Revenue	1,050,284	45
46	Medicare - Net Inpatient Revenue	1,066,012	46
47	Other-(specify) Hospice	14,078	47
48	Other-(specify) Insurance	536,186	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,984,442	49

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

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

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	883	962	$ 36,369	$ 37.81	1
2	Assistant Director of Nursing	6,064	6,612	195,915	29.63	2
3	Registered Nurses	14,550	15,867	453,555	28.58	3
4	Licensed Practical Nurses	16,246	17,716	402,746	22.73	4
5	CNAs & Orderlies	44,823	49,075	598,344	12.19	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,588	13,740	570,492	41.52	7
8	Rehab/Therapy Aides	14,987	16,359	463,055	28.31	8
9	Activity Director	3,863	4,220	50,799	12.04	9
10	Activity Assistants					10
11	Social Service Workers	7,474	8,164	153,602	18.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,881	14,279	150,851	10.56	15
16	Dishwashers					16
17	Maintenance Workers	1,715	1,874	37,588	20.06	17
18	Housekeepers	5,211	5,697	51,804	9.09	18
19	Laundry	3,664	4,003	40,993	10.24	19
20	Administrator	2,080	2,080	96,557	46.42	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,605	9,557	215,062	22.50	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	1,900	2,075	25,115	12.10	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	2,096	2,291	29,163	12.73	33
34	TOTAL (lines 1 - 33)	159,630	174,571	$ 3,572,010 *	$ 20.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,589	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,589		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	146	$ 9,009	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	146	$ 9,009		53

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Helms	Administrator	0	$ 96,557
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,557

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 251,580
TOTAL (agree to Schedule V, line 17, col. 3)	$ 251,580
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Anspach Meeks Ellenberger LLP	Legal Fees	$ 69
Greenberg Traurig	Legal Fees	2,383
Polsinelli Shughart PC	Legal Fees	104
SNF Global	Legal Fees	30,363
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)		
Healthlink Inc	Collection Services	1,626
Michael T Mahoney LTD	Collection Services	2,439
Transworld Systems Inc	Collection Services	3,879
(Collection Costs were adjusted off via Page 5a, Line 5).		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 40,863

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,843
Unemployment Compensation Insurance	39,195
FICA Taxes	250,918
Employee Health Insurance	134,486
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LT Incentive	6,667
401K	6,535
Appreciation, Oth Benefits & Mktg Adj	22,238
Tuition Program	
SMSP Match	26
Employee Uniforms	4,892
Home Office Allocation	22,291
TOTAL (agree to Schedule V, line 22, col.8)	$ 549,091

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	25,353
Health Care Worker Background Check	
(Indicate # of checks performed 350)	6,835
Patient Background Checks 400	4,000
Dues & Subscriptions	3,578
Association Dues	4,216
Advertising	31,917
Other Licensesand Permits	1,173
Less: Non-Allowable Association Dues	(1,452)
Less: Public Relations Expense	( )
Non-allowable advertising	(31,917)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,683

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,874
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,874

**See instructions.

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/15 Ending: 05/31/16

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. **ICHA $1,754 & ACHA $1,010**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **24,713** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **04/07/11**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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 Departmen
during this cost report period. $ **110,861**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **5,899**

(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 fo
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
out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **NO**
Attach invoices and a summary of services for all architect and appraisal fees