FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 06/01/16 to 05/31/17 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) A. Dean Shipman
	(Title) Assistant Vice President
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: 06/01/16 Ending: 05/31/17

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	25,915	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	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,926	3,191	15,560	20,677	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,926	3,191	15,560	20,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.79%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 9,917

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: 06/01/16 Ending: 05/31/17

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	164,408		15,798	180,206		180,206		180,206			1
2	Food Purchase		151,000		151,000		151,000	(9,876)	141,124			2
3	Housekeeping	87,088	18,161		105,249		105,249		105,249			3
4	Laundry	36,209	13,200	58	49,467		49,467		49,467			4
5	Heat and Other Utilities			150,822	150,822	1,238	152,060		152,060			5
6	Maintenance	50,346	23,792	58,534	132,672		132,672		132,672			6
7	Other (specify):* Medical Waste			207	207		207		207			7
8	**TOTAL General Services**	338,051	206,153	225,419	769,623	1,238	770,861	(9,876)	760,985			8
	B. Health Care and Programs											
9	Medical Director			22,153	22,153		22,153		22,153			9
10	Nursing and Medical Records	1,824,917	198,193	97,682	2,120,792	30	2,120,822		2,120,822			10
10a	Therapy	1,088,270	10,719	15,721	1,114,710		1,114,710		1,114,710			10a
11	Activities	50,804	60	2,099	52,963		52,963		52,963			11
12	Social Services	175,642	577		176,219		176,219		176,219			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,139,633	209,549	137,655	3,486,837	30	3,486,867		3,486,867			16
	C. General Administration											
17	Administrative	103,065		293,129	396,194	(96,407)	299,787		299,787			17
18	Directors Fees											18
19	Professional Services			75,509	75,509		75,509	(75,509)				19
20	Dues, Fees, Subscriptions & Promotions			71,013	71,013		71,013	(22,093)	48,920			20
21	Clerical & General Office Expenses	310,043	47,854	411,225	769,122		769,122	(341,327)	427,795			21
22	Employee Benefits & Payroll Taxes			517,878	517,878	24,684	542,562		542,562			22
23	Inservice Training & Education			3,730	3,730		3,730		3,730			23
24	Travel and Seminar			33,145	33,145		33,145		33,145			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			353,844	353,844		353,844		353,844			26
27	Other (specify):*											27
28	**TOTAL General Administration**	413,108	47,854	1,759,473	2,220,435	(71,723)	2,148,712	(438,929)	1,709,783			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,890,792	463,556	2,122,547	6,476,895	(70,455)	6,406,440	(448,805)	5,957,635			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			184,674	184,674	9,491	194,165		194,165			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,684	161,684	60,964	222,648	(161,772)	60,876			32
33	Real Estate Taxes			81,354	81,354		81,354		81,354			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			103,111	103,111		103,111		103,111			35
36	Other (specify):*											36
37	TOTAL Ownership			530,823	530,823	70,455	601,278	(161,772)	439,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		573,860		573,860		573,860		573,860			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	30,800			30,800		30,800		30,800			41
42	Provider Participation Fee			103,588	103,588		103,588		103,588			42
43	Other (specify):* IV | X-Ray & Lab		60,982	109,418	170,400		170,400		170,400			43
44	TOTAL Special Cost Centers	30,800	634,842	213,006	878,648		878,648		878,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,921,592	1,098,398	2,866,376	7,886,366		7,886,366	(610,577)	7,275,789			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: 06/01/16 Ending: 05/31/17

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 Refer- ence	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	(9,876)	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	(333)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	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	(17,126)	21		18
19	Entertainment				19
20	Contributions	(1,590)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(49,402)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(322,606)	21		24
25	Fund Raising, Advertising and Promotional	(22,093)	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	(187,436)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (610,577)		$	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))**	$ (610,577)		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: 06/01/16

Ending: 05/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ 0	11	1
2	Misc. Income	443	21	2
3	Vending Income	0	21	3
4	Donations Revenue	0	21	4
5	Accouning/Collection Fees	(26,107)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(161,772)	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**	(187,436)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,876)	0	0	0	0	0	0	0	0	0	0	(9,876)	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**	(9,876)	0	0	0	0	0	0	0	0	0	0	(9,876)	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	(75,509)	0	0	0	0	0	0	0	0	0	0	(75,509)	19
20	Fees, Subscriptions & Promotions	(22,093)	0	0	0	0	0	0	0	0	0	0	(22,093)	20
21	Clerical & General Office Expenses	(341,327)	0	0	0	0	0	0	0	0	0	0	(341,327)	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**	(438,929)	0	0	0	0	0	0	0	0	0	0	(438,929)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(448,805)	0	0	0	0	0	0	0	0	0	0	(448,805)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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

	Capital Expense D. Ownership	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)	
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	(161,772)	0	0	0	0	0	0	0	0	0	0	(161,772)	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**	(161,772)	0	0	0	0	0	0	0	0	0	0	(161,772)	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)**	(610,577)	0	0	0	0	0	0	0	0	0	0	(610,577)	45

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 280,368	HCR Manor Care Services, LLC	100.00%	$ 280,368	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,921,592	Heartland Employment Services, LLC	100.00%	3,921,592		4
5	V	10a	Therapy Management	8,142	Heartland Rehabilitation Services, LLC	100.00%	8,142		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			$ 4,210,102			$ 4,210,102	$ *	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: 06/01/16 Ending: 05/31/17

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 06/01/16 Ending: 05/31/17

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	3,762,500,577	561 nfS, hhS, &	$ 619,847	$ 0	7,513,849	$ 1,238	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	0	0	7,513,849	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	7,513,849	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	14,966	9,743	7,513,849	30	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	0	0	7,513,849	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	7,513,849	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	61,861,920	32,341,614	7,513,849	123,540	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	14,679,699	5,396,995	7,513,849	33,486	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	2,741,751	0	7,513,849	26,935	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	5,141,603	0	7,513,849	10,267	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	6,319,907	0	7,513,849	14,417	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	0	0	7,513,849	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	3,929,156	0	7,513,849	7,847	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	720,726	0	7,513,849	1,644	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	7,513,849	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,762,500,577		30,527,148		7,513,849	60,964	22
23	32	Directly Assigned Interest	Not Allocated			18,393,998				23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				31,980,611				24
25	TOTALS					$ 176,931,332	$ 37,748,352		$ 280,368	25

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	Conv. Sub. Debentures		X				$	$		#DIV/0!	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										60,964	6
7	Interest Income / Interest Expense										(88)	7
8												8
9	TOTAL Facility Related						$	$			$ 60,876	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 60,876	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: 06/01/16 Ending: 05/31/17

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2016 report.	$	73,718	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.)	$	80,749	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,031	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	74,323	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	81,354	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2012	79,423	8
2013	79,916	9
2014	79,446	10
2015	80,419	11
2016	81,079	12

Line 2: $80,749.39 = $40,209.75 for 2nd half 2015 + $40,539.64 for 1st half 2016

Line 4: $74,322.97= $40,539.64 for 2nd half 2016 + $33,783.33 for Jan - May 2017

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-25-100-013	See Attached	$ 18,414.46	$ 2,946.31
2.	01-01-14-400-021	See Attached	$ 333.56	$ 53.37
3.	01-01-23-200-025	See Attached	$ 487,997.50	$ 78,079.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 506,745.52	$ 81,079.28

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

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).

None

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	2	3	4	
	Use	Square Feet	Year Acquired	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: 06/01/16 Ending: 05/31/17

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	$ 79,311		$ 79,311	$	$ 1,096,711	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					65,247		65,247		1,748,259	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: 06/01/16 Ending: 05/31/17

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	$ 144,558		$ 144,558	$	$ 2,844,970	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: 06/01/16 Ending: 05/31/17

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,741,675	$ 144,558		$ 144,558	$	$ 2,844,970	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	$ 144,558		$ 144,558	$	$ 2,844,970	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: 06/01/16 Ending: 05/31/17

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,616,088	$ 144,558		$ 144,558	$	$ 2,844,970	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	3,777						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	$ 144,558		$ 144,558	$	$ 2,844,970	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: 06/01/16 Ending: 05/31/17

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 12C, Carried Forward		$ 5,011,826	$ 144,558		$ 144,558	$	$ 2,844,970	1
2	HVAC System to replace PTAC in breakroom	2016	10,424						2
3	Fire Alarm wiring and devices on 4th floor a-wing, back hallway a	2016	11,205						3
4									4
5									5
6									6
7									7
8									8
9									9
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,033,455	$ 144,558		$ 144,558	$	$ 2,844,970	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: 06/01/16 Ending: 05/31/17

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	$ 1,570,501	$ 40,117	$ 40,117	$		$ 1,493,157	71
72	Current Year Purchases	29,331						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			9,491	9,491			74
75	TOTALS	$ 1,599,832	$ 40,117	$ 49,608	$ 9,491		$ 1,493,157	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)	$ 6,968,802	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,675	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,166	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,491	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,338,127	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: 06/01/16 Ending: 05/31/17

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

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.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: $ 75,582 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		$	$ 27,529	17
18					18
19					19
20					20
21	TOTAL		$	$ 27,529	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: 06/01/16 Ending: 05/31/17

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.

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3,380 hrs	$ 146,134		$	$ 143	3,380	$ 146,277	1
2	Licensed Speech and Language Development Therapist	10a	1556 hrs	67,270				1,556	67,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4,253 hrs	183,881			10,576	4,253	194,457	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				573,860		573,860	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhalation Therapist	10a, 3			241	15,194		241	15,194	12
13	Other (specify): IV Therapy/X-Ray/Lab	43, 2 & 3				109,418	60,982		170,400	13
14	TOTAL			$ 397,285	241	$ 124,612	$ 645,561	9,430	$ 1,167,458	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: 06/01/16 Ending: 05/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/17 (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	$ 6,460	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (290,135))	922,576		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)**	$ 931,633	$	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	5,033,455		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,599,832		16
17	Accumulated Depreciation (book methods)	(4,338,127)		17
18	Deferred Charges	75,365		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	76,341		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,782,381	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,714,014	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 204,210	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	262,017		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,323		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	77,243		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 617,793	$	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)**	$ 617,793	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,096,221	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,714,014	$	48

*(See instructions.)

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,467,853	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,467,853	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,008	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)**	$ 390,008	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(761,640)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (761,640)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,096,221	24 *

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 8,392,577	1
2	Discounts and Allowances for all Levels	(5,456,448)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,936,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,919,042	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,919,042	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	1,123	13
14	Non-Patient Meals	9,876	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,145,713	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	162,653	19
20	Radiology and X-Ray	74,204	20
21	Other Medical Services	25,146	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,418,715	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	Misc Inc, QI Pymts & Purch Disc	2,488	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,488	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,276,374	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	769,623	31
32	Health Care	3,486,837	32
33	General Administration	2,220,435	33
	B. Capital Expense		
34	Ownership	530,823	34
	C. Ancillary Expense		
35	Special Cost Centers	775,060	35
36	Provider Participation Fee	103,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,886,366	40
41	**Income before Income Taxes (line 30 minus line 40)****	390,008	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 390,008	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 244,648	44
45	Private Pay - Net Inpatient Revenue	834,842	45
46	Medicare - Net Inpatient Revenue	1,033,745	46
47	Other-(specify) Hospice	8,785	47
48	Other-(specify) Insurance	812,507	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,934,527	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: 06/01/16 Ending: 05/31/17

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,426	1,564	$ 67,406	$ 43.10	1
2	Assistant Director of Nursing	6,717	7,365	231,547	31.44	2
3	Registered Nurses	16,807	18,428	542,955	29.46	3
4	Licensed Practical Nurses	14,091	15,450	357,042	23.11	4
5	CNAs & Orderlies	44,449	48,784	600,981	12.32	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	11,579	12,678	548,105	43.23	7
8	Rehab/Therapy Aides	16,475	18,039	540,165	29.94	8
9	Activity Director	3,780	4,150	50,804	12.24	9
10	Activity Assistants					10
11	Social Service Workers	8,082	8,870	175,642	19.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,795	19,808	164,408	8.30	15
16	Dishwashers					16
17	Maintenance Workers	2,061	2,257	50,346	22.31	17
18	Housekeepers	7,721	8,471	87,088	10.28	18
19	Laundry	3,233	3,547	36,209	10.21	19
20	Administrator	2,080	2,080	103,065	49.55	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,909	13,124	310,043	23.62	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	1,848	2,026	24,986	12.33	31
32	Other Health Care(specify)					32
33	Other(specify)	2,031	2,224	30,800	13.85	33
34	TOTAL (lines 1 - 33)	172,084	188,865	$ 3,921,592 *	$ 20.76	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	22,153	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)		$ 22,153		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland of Riverview # 0049486 Report Period Beginning: 06/01/16 Ending: 05/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wade Cies	Administrator	0	$ 94,065
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,065

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 280,368
Purchase Service Administrator - Antonio Thomas	12,761
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 293,129

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 49,402
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	26,107
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 75,509

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,129
Unemployment Compensation Insurance	42,503
FICA Taxes	271,929
Employee Health Insurance	111,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	11,475
Appreciation, Oth Benefits & Mktg Adj	14,573
Tuition Program	
Smsp Match	142
Employee Uniforms	8,474
Home Office Allocation	24,684
TOTAL (agree to Schedule V, line 22, col.8)	$ 542,562

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	$
Advertising: Employee Recruitment	27,588
Health Care Worker Background Check (Indicate # of checks performed 322)	8,342
Patient Background Checks 483	4,830
Dues & Subscriptions	4,664
Association Dues	4,451
Advertising	20,657
Other Licenses and Permits	481
Less: Non-Allowable Association Dues	(1,436)
Less: Public Relations Expense	( )
Non-allowable advertising	(20,657)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,920

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	33,145
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)	$ 33,145

**See instructions.

Facility Name & ID Number **Heartland of Riverview** **#** **0049486** **Report Period Beginning:** **06/01/16** **Ending:** **05/31/17**

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 $1,973 & AHCA $1,041**

(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. $ **25,278** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **103,588**
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. $ **9,876**

(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 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