

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0049940</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Riviera Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> 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.	
Address: <u>490 West 16Th Place</u> <u>Chicago Heights</u> <u>60411</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 481-4444</u> Fax # <u>(708) 481-4606</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>05/01/08</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steve Lavenda</u>		Telephone Number: <u>(847) 236-1111</u>	
Email Address: _____			

Officer or Administrator of Provider

Paid Preparer

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

(Signed) _____ (Date) _____

(Print Name and Title) Cary C. Buxbaum, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Riviera Care Center

0049940 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>100</u>	<u>36,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>100</u>	Intermediate (ICF)	<u>100</u>	<u>36,500</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,000</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>66,162</u>	<u>320</u>		<u>66,482</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,162</u>	<u>320</u>		<u>66,482</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.07%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 5/1/2008

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 5/1/2008 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 45 and days of care provided 0

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Riviera Care Center # 0049940 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	215,524	18,552	14,385	248,461		248,461	517	248,978			1
2	Food Purchase		281,784		281,784	(23,543)	258,242	(14)	258,228			2
3	Housekeeping	158,474	25,025		183,499		183,499		183,499			3
4	Laundry	32,207	25,985		58,192		58,192		58,192			4
5	Heat and Other Utilities			145,597	145,597		145,597	1,616	147,213			5
6	Maintenance	79,046	51,505	41,268	171,819		171,819	31,816	203,635			6
7	Other (specify):*							1,883	1,883			7
8	TOTAL General Services	485,251	402,851	201,250	1,089,352	(23,543)	1,065,810	35,818	1,101,628			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	1,480,851	66,225	67,900	1,614,976		1,614,976	4,413	1,619,389			10
10a	Therapy	191,244		240	191,484		191,484		191,484			10a
11	Activities	106,355	7,614	1,792	115,761		115,761		115,761			11
12	Social Services	202,298		4,152	206,450		206,450		206,450			12
13	CNA Training											13
14	Program Transportation			802	802		802	4,073	4,875			14
15	Other (specify):*							7,907	7,907			15
16	TOTAL Health Care and Programs	1,980,748	73,839	94,086	2,148,673		2,148,673	16,393	2,165,066			16
	C. General Administration											
17	Administrative	140,125		46,800	186,925		186,925	50,945	237,870			17
18	Directors Fees											18
19	Professional Services			254,779	254,779	(22,016)	232,763	(150,945)	81,818			19
20	Dues, Fees, Subscriptions & Promotions			75,777	75,777		75,777	(37,089)	38,688			20
21	Clerical & General Office Expenses	124,869	1,953	208,910	335,732		335,732	(45,102)	290,630			21
22	Employee Benefits & Payroll Taxes			612,457	612,457	23,543	636,000		636,000			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,844	2,844		2,844	1,584	4,428			24
25	Other Admin. Staff Transportation			9,613	9,613		9,613	3,721	13,334			25
26	Insurance-Prop.Liab.Malpractice			130,236	130,236		130,236	2,247	132,483			26
27	Other (specify):*							28,317	28,317			27
28	TOTAL General Administration	264,994	1,953	1,341,416	1,608,363	1,527	1,609,890	(146,322)	1,463,568			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,730,993	478,643	1,636,752	4,846,388	(22,016)	4,824,372	(94,111)	4,730,261			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			91,524	91,524		91,524	207,102	298,626			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,082	68,082		68,082	461,534	529,616			32
33	Real Estate Taxes					22,016	22,016	348,841	370,857			33
34	Rent-Facility & Grounds			974,000	974,000		974,000	(974,000)				34
35	Rent-Equipment & Vehicles			8,488	8,488		8,488	6,681	15,169			35
36	Other (specify):*											36
37	TOTAL Ownership			1,142,094	1,142,094	22,016	1,164,110	50,158	1,214,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*	79,511		306,780	386,291		386,291	(386,291)				43
44	TOTAL Special Cost Centers	79,511		416,280	495,791		495,791	(386,291)	109,500			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,810,504	478,643	3,195,126	6,484,273		6,484,273	(430,243)	6,054,030			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,465)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,115	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,913)	21		18
19	Entertainment	(5,472)	21		19
20	Contributions	(26,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,429)	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	(422,967)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (578,744)		\$	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)	148,501		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 148,501		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (430,243)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Riviera Care Center

ID#	0049940
Report Period Beginning:	01/01/11
Ending:	12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
			Amount	Reference
1	Miscellaneous Income	\$	(2,516)	211
2	Marketing Wages		(79,511)	432
3	Bank Charges		(19,116)	213
4	Marketing Fees		(10,780)	434
5	COPE Dues		(4,914)	205
6	Building Company - Bank Charges		(503)	216
7	Building Company - Accounting Fees		(8,500)	197
8	Building Company - License & Fees		(250)	218
9	Building Company - Amortization		(15,536)	369
10	2011 Seminar Expense		95	2410
11	Prior Period professional fees		(750)	1911
12	Additional R&M		30,534	0612
13	Non Allowable Legal		(12,717)	1913
14	Non-Allowable Auto Lease		(2,503)	3514
15	Non-Allowable Fees		(296,000)	4315
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		(422,967)	49

Riviera Care Center

ID# 0049940

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
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77				28
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80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

Summary A

12/31/11

[illegible]

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
See 6 Supplemental		See 6-Supplemental		See 6-Supplemental		
				Riviera Realty, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 960,000	Riviera Realty, LLC		\$	\$ (960,000)	1
2	V	32	Interest	4,441	Riviera Realty, LLC			(4,441)	2
3	V	21	Bank Charges		Riviera Realty, LLC		503	503	3
4	V	19	Accounting Fees		Riviera Realty, LLC		8,500	8,500	4
5	V	19	Legal Fees- R/E Tax Appeal		Riviera Realty, LLC		19,081	19,081	5
6	V	21	License & Fees		Riviera Realty, LLC		250	250	6
7	V	32	Interest Mortgage		Riviera Realty, LLC		378,149	378,149	7
8	V	33	Real Estate Taxes		Riviera Realty, LLC		345,753	345,753	8
9	V	32	Interest Expense-Seller		Riviera Realty, LLC		16,549	16,549	9
10	V	30	Depreciation		Riviera Realty, LLC		198,672	198,672	10
11	V	36	Amortization - Loan Fees		Riviera Realty, LLC		15,536	15,536	11
12	V	32	Interest-Construction Loan		Riviera Realty, LLC		65,313	65,313	12
13	V								13
14	Total			\$ 964,441			\$ 1,048,306	\$ * 83,865	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 1,616	\$ 1,616	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,747	2,747	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	194	194	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	37,915	37,915	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,831	2,831	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	698	698	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	94,670	94,670	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	1,079	1,079	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	3,136	3,136	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,247	2,247	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	25,096	25,096	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,765	1,765	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	107	107	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	4,934	4,934	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	16,580	16,580	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,923	1,923	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	680	680	31
32	V				YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V	19	OTHER PROFESSIONAL FEES	1,000	YAM MANAGEMENT, LLC	100.00%		(1,000)	34
35	V	19	BOOKKEEPING FEES	109,500	YAM MANAGEMENT, LLC	100.00%		(109,500)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	14,000	YAM MANAGEMENT, LLC	100.00%		(14,000)	37
38	V	19	DATA PROCESSING	1,454				(1,454)	38
39	Total			\$ 161,954			\$ 198,218	\$ * 36,264	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 14,102	\$	14,102 15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,689		1,689 16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	63,513		63,513 17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,073		4,073 18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	7,907		7,907 19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	20,830		20,830 20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	5,524		5,524 21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	90		90 22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	11,389		11,389 23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	410		410 24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	585		585 25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,221		3,221 26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	72		72 27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	6,581		6,581 28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	13,585	YAM CONSULTING, LLC	100.00%			(13,585) 33
34	V	10	NURSE CONSULTING	59,100	YAM CONSULTING, LLC	100.00%			(59,100) 34
35	V	17	DIR. OF OPERATIONS CONSULT	7,800	YAM CONSULTING, LLC	100.00%			(7,800) 35
36	V	19	DATA PROCESSING FEES	17,509	YAM CONSULTING, LLC	100.00%			(17,509) 36
37	V	21	MARKETING	7,250	YAM CONSULTING, LLC	100.00%			(7,250) 37
38	V								38
39	Total			\$ 105,244			\$ 139,986	\$ *	34,742 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 549	\$ 549	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		66	66	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		106	106	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		5,478	5,478	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		5,857	5,857	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,088	3,088	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	16,580	8131 N. MONTICELLO, LLC			(16,580)	26
27	V	33	REAL ESTATE TAXES	4,934	8131 N. MONTICELLO, LLC			(4,934)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 21,514			\$ 15,144	\$ * (6,370)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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.

YESNO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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	1219 LIMITED PARTNERSHIP	7.500%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	RIVIERA REALTY, LLC	SKOKIE	BUILDING CO.	1
2	257 LIMITED PARTNERSHIP	7.500%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	2
3	42170 LIMITED PARTNERSHIP	7.500%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	3
4	CHRISTINA INOFRE	0.500%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	4
5	CONGREGATION TIFERES AVROHOM	4.250%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	DAVID BERKOWITZ	20.500%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	DENNIS RUBEN	4.500%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8	GARY BIDER	1.750%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				8
9	ISADORE MEYSTELE REVOCABLE TRUST	2.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				9
10	JOYCE RUBEN	4.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				10
11	MOSHE EPSTEIN	4.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				11
12	RACHEL ESFORMES	2.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				12
13	REBECCA LAFER	2.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				13
14	SHELDON WROTSLAVSKTY	1.000%	ROCKFORD NUR. & REHAB	ROCKFORD				14
15	YOSEF MEYSTELE	28.500%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16	ZALMEN STEIN	0.500%						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

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								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Riviera Care Center # 0049940 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	28.50%	See Attached	4.3	10.75%	Mgmt. Fees	\$ 15,000	17-3	1
2	David Berkowitz	Owner	Administrative	20.50%	See Attached	4.3	10.75%	Mgmt. Fees	24,000	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.1	5.25%	Alloc. Salary	6,430	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.1	10.50%	Alloc. Salary	2,448	17-7	4
5	Christina Inofre	Owner	Nursing	0.50%	See Attached	4.3	10.75%	Alloc. Salary	11,323	10-7	5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable										10
11	by the Il. Dept of HFS.										11
12											12
13								TOTAL	\$ 59,201		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

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Riviera Care Center # 0049940 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization YAM MANAGEMENT, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. BED DAYS	686,836	17	\$ 15,204	\$	73,000	\$ 1,616	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	73,000	2,747	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		73,000	194	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	73,000	37,915	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		73,000	2,831	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		73,000	698	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	73,000	94,670	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		73,000	1,079	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		73,000	3,136	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		73,000	2,247	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		73,000	25,096	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		73,000	1,765	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		73,000	107	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		73,000	4,934	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		73,000	16,580	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		73,000	1,923	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		73,000	680	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,864,985	\$ 1,200,907		\$ 198,218	25

Ending: 12/31/11

(847) 673-6768

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

(847) 673-6768

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

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Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Riviera Care Center # 0049940 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

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	Lake Forest		X	Mortgage Payable			\$	6,500,000			\$	378,149	1
2	First Bank		X	Construction								65,313	2
3	Note Payable Seller		X					194,444				16,549	3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Line of Credit		X	Line of Credit				1,070,162				65,148	6
7	GMAC							11,889				2,647	7
8	See Supplemental Schedule							1,100,000				287	8
9	TOTAL Facility Related						\$	8,876,495			\$	528,093	9
	B. Non-Facility Related*												
10	Interest Income-Building Co.		X									(4,441)	10
11	Allocated from YAM Management											107	11
12	Allocated from 8131 N. Monticello											5,857	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	1,523	14
15	TOTALS (line 9+line14)						\$	8,876,495			\$	529,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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	
6													6	
7	TOTAL Long-Term												7	
	Working Capital													
8	Insurance Premium Financing		X				\$		\$			\$	287	8
9	Lake Forest			Line of Credit					1,100,000					9
10														10
11														11
12														12
13														13
14	TOTAL Working Capital								1,100,000				287	14
	B. Non-Facility Related*													
15							\$		\$			\$		15
16														16
17														17
18														18
19														19
20	TOTAL Non-Facility Related													20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	385,000		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.)		\$	348,841		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(36,159)		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	385,000		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.)		\$	22,016		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 \$ 53,931 For 2008 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.		\$	370,857		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007	204,231	9	
		2008	353,752	10	
		2009	368,883	11	
		2010	345,753	12	
Beginning Accrual Adjusted					
Allocated from 8131 N. Monticello- \$3,088					
Allocated from YAM Management- \$4,934					
2011 Accrual- \$345,753 x 1.11%= \$385,000					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		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.**

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Riviera Care Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0049940

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>32-19-417-085-0000</u>	<u>Long Term Care Property</u>	\$ <u>731.44</u>	\$ <u>731.44</u>
2. <u>32-19-417-112-0000</u>	<u>Long Term Care Property</u>	\$ <u>374,217.33</u>	\$ <u>374,217.33</u>
3. <u>32-19-417-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>651.41</u>	\$ <u>651.41</u>
4. <u>32-19-417-098-0000</u>	<u>Long Term Care Property</u>	\$ <u>184.92</u>	\$ <u>184.92</u>
5. <u>32-19-417-101-0000</u>	<u>Long Term Care Property</u>	\$ <u>864.71</u>	\$ <u>864.71</u>
6. <u>32-19-417-102-0000</u>	<u>Long Term Care Property</u>	\$ <u></u>	\$ <u></u>
7. <u>32-19-417-103-0000</u>	<u>Long Term Care Property</u>	\$ <u>864.71</u>	\$ <u>864.71</u>
8. <u>32-19-417-104-0000</u>	<u>Long Term Care Property</u>	\$ <u>864.71</u>	\$ <u>864.71</u>
9. <u>32-19-417-105-0000</u>	<u>Long Term Care Property</u>	\$ <u>389.37</u>	\$ <u>389.37</u>
10. <u>See Attached</u>	<u></u>	\$ <u>2,002.02</u>	\$ <u>2,002.02</u>
TOTALS		\$ <u>380,770.62</u>	\$ <u>380,770.62</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Riviera Care Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0049940

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>32-19-417-049-0000</u>	<u>Long Term Care Property</u>	\$ <u>389.37</u>	\$ <u>389.37</u>
2. <u>32-19-417-052-0000</u>	<u>Long Term Care Property</u>	\$ <u>389.37</u>	\$ <u>389.37</u>
3. <u>32-19-417-053-0000</u>	<u>Long Term Care Property</u>	\$ <u>389.37</u>	\$ <u>389.37</u>
4. <u>32-19-417-106-0000</u>	<u>Long Term Care Property</u>	\$ <u>833.91</u>	\$ <u>833.91</u>
5. <u>10-23-325-045-0000</u>	<u>Allocated from 8131 N. Monticello</u>	\$ <u>35,987.49</u>	\$ <u>3,350.57</u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>37,989.51</u>	\$ <u>5,352.59</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

67,120

B. General Construction Type:

Exterior

Brick/Blocks

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	72,000	2008	\$ 240,000	1
2	Allocated from 8131 N. Monticello			9,459	2
3	TOTALS	72,000		\$ 249,459	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	200			1967	\$ 3,912,270	\$ 198,672	40	\$ 97,807	\$ (100,865)	\$ 358,626	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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29											29
30											30
31											31
32											32
33											33
34											34
35											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

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	
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								49
50								50
51								51
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55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,105,185			55,267	55,267	177,446	67
68		109,922	5,828		3,881	(1,947)	5,726	68
69			91,524			(91,524)		69
70		\$ 5,127,377	\$ 296,024		\$ 156,955	\$ (139,069)	\$ 541,798	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Riviera Care Center

0049940

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,127,377	\$ 296,024		\$ 156,955	\$ (139,069)	\$ 541,798	1
2	Gas Piping	2008	4,300		20	215	215	699	2
3	Pedestrian Doors	2008	6,246		20	312	312	989	3
4	Drywall & Floor Tile, New Window & Paint, New Toilet & Bath -	2009	12,826		20	641	641	1,924	4
5	Doorwork	2009	6,577		20	658	658	1,809	5
6	Fans/Painting/Molding/Flooring/Drywall	2009	4,641		20	464	464	1,199	6
7	Plumbing/Millwork/Hardware	2009	4,073		20	407	407	1,052	7
8	Electrical/Lighting	2009	4,671		20	467	467	1,246	8
9	Millwork/Electrical/Wallcoverings	2009	4,029		20	403	403	1,007	9
10	Security Camera	2009	3,260		20	466	466	1,281	10
11	Exterior Signs	2009	3,478		20	348	348	956	11
12	Hvac Unit	2009	4,160		20	347	347	953	12
13	Electrical/Wiring	2009	4,264		20	426	426	1,279	13
14	Rehab Room #158- Ceiling/Walls, Paint, Cove Base, Tiles, Electric	2009	4,607		20	461	461	1,382	14
15	Rehab Room #159- Ceiling/Walls, Paint, Cove Base, Tiles, Electric	2009	4,607		20	461	461	1,382	15
16	Rehab Room #162- Ceiling/Walls, Paint, Cove Base, Tiles, Electric	2009	4,742		20	474	474	1,423	16
17	Rehab Room #161- Ceiling/Walls, Paint, Cove Base, Tiles, Electric	2009	4,742		20	474	474	1,423	17
18	Rehab Room #160- Ceiling/Walls, Paint, Cove Base, Tiles, Electric	2009	6,447		20	645	645	1,934	18
19	Electrical/Wiring/Plumbing	2009	4,081		20	408	408	1,224	19
20	Remove Asbestos Flr Tile	2009	5,720		20	572	572	1,716	20
21	Elevator Upgrades	2009	3,470		20	347	347	1,041	21
22	Electrical/Lighting/Flooring/Plumbing	2009	4,532		20	453	453	1,020	22
23	Flooring/Hardware/Electrical/Lighting	2009	5,066		20	507	507	1,098	23
24	Electrical/Lighting/Flooring/Plumbing	2009	6,218		20	622	622	1,295	24
25	Fuse Panels & Circuitry	2009	57,900		20	2,895	2,895	8,685	25
26	Rms 101-104,110-111,154-157 Ceiling Tiles, Toilet, Doors, Flooring	2009	53,430		20	2,672	2,672	7,347	26
27	Activity Room - Ceiling Suspension, Walls, Tiles	2009	9,005		20	450	450	1,238	27
28	Shower Room - Wall Tiles, Plumbing, Painting, Doors, Emergency	2009	24,750		20	1,238	1,238	3,403	28
29	Activity Room - Flooring	2009	3,332		20	333	333	889	29
30	Dining Room - Flooring	2009	8,280		20	414	414	1,104	30
31	Paint Work - East & South Elevations	2009	5,025		20	251	251	670	31
32	Water Heater, Piping, Valves, Pumps, Walk-In Freezer	2009	37,870		20	1,894	1,894	5,207	32
33	Entrance Doors	2009	6,469		20	323	323	863	33
34	TOTAL (lines 1 thru 33)		\$ 5,450,194	\$ 296,024		\$ 178,002	\$ (118,022)	\$ 600,534	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Riviera Care Center

0049940

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,450,194	\$ 296,024		\$ 178,002	\$ (118,022)	\$ 600,534	1
2	Wooden Fence - South Side	2009	12,610		20	631	631	1,734	2
3	Shower Room - Exhaust Fans, Duct, Electric Work	2009	2,700		20	135	135	349	3
4	Replace 1" Water Main With 2" Meter To Solve Low Pressure Iss	2010	3,035		20	304	304	607	4
5	Electrical - Emergency Repair	2010	7,111		20	711	711	1,422	5
6	Room 133 Bathroom-Paint, Install Light Fixtures, Replace Tile, Ti	2010	3,230		20	323	323	592	6
7	Room 144, 146 Bathroom-Paint, Install Light Fixtures, Replace Ti	2010	3,730		20	373	373	684	7
8	Cameras & Wiring For Security System	2010	9,265		20	1,853	1,853	3,397	8
9	Fence	2010	4,750		20	317	317	475	9
10	Kitchen & Bath Flooring, Hardware, Plumbing	2010	2,733		20	273	273	410	10
11	Resident Bath-Tile, Toilet, Sink, Vanity, Mirror, Paint, Plumbing	2010	3,230		20	323	323	485	11
12	Resident Bath-Tile, Toilet, Sink, Vanity, Mirror, Paint, Plumbing	2010	3,230		20	323	323	485	12
13	Employee Bath-Tile, Toilet, Vanity, Mirror, Paint, Plumbing	2010	3,000		20	300	300	425	13
14	Resident Bath-Tile, Toilet, Sink, Tub, Vanity, Mirror, Paint, Plumb	2010	3,730		20	373	373	528	14
15	Back Up Pump	2010	4,048		20	405	405	540	15
16	Resident Bath-Floor & Wall Tile, Toilet, Sink, Tub, Vanity, Mirro	2010	3,530		20	353	353	471	16
17	Resident Bath-Tile, Toilet, Sink, Tub, Vanity, Mirror, Paint, Plum	2010	3,730		20	373	373	497	17
18	Resident Bath-Tile, Toilet, Sink, Vanity, Mirror, Paint, Plumbing	2010	3,230		20	323	323	431	18
19	Resident Bath-Tile, Toilet, Sink, Vanity, Mirror, Paint, Plumbing	2010	3,230		20	323	323	431	19
20	Flooring	2010	23,125		20	2,313	2,313	2,891	20
21	Sink	2010	2,845		20	569	569	711	21
22	Kitchen & Bath Plumbing, Hardware, Electrical & Lighting Mate	2010	2,976		20	298	298	347	22
23	Locks & Keys For Storeroom & Entrances	2010	3,076		20	154	154	295	23
24	Flooring, Hardware	2010	3,882		20				24
25	Electrical, Lighting, Lumber,Paint, Plumbing, Hardware, Flooring	2010	5,801		20				25
26	50 Stainless Steel Sider Rail Covers	2011	2,725		20	23	23	23	26
27	Flooring - Remove Existing And Install New Cove Base, Tiles, Red	2011	26,048		20	1,383	1,383	1,383	27
28	Electric For Actuator	2011	4,475		20	149	149	149	28
29	Replace Concrete Driveway, Retaining Wall	2011	16,550		20	483	483	483	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,621,820	\$ 296,024		\$ 191,387	\$ (104,637)	\$ 620,777	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 5,621,820	\$ 296,024		\$ 191,387	\$ (104,637)	\$ 620,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,621,820	\$ 296,024		\$ 191,387	\$ (104,637)	\$ 620,777	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12D, Carried Forward		\$ 5,621,820	\$ 296,024		\$ 191,387	\$ (104,637)	\$ 620,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,621,820	\$ 296,024		\$ 191,387	\$ (104,637)	\$ 620,777	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Riviera Care Center

0049940

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	NURSE CALL SYSTEM	2008	18,272		20	914	914	3,656	9
10	CEILING TILES	2008	33,092		20	1,655	1,655	6,620	10
11	LIGHT FIXTURES	2008	20,266		20	1,013	1,013	4,052	11
12	WROUGHT IRON RAILINGS	2008	6,398		20	320	320	1,280	12
13	FIRE DAMPERS	2008	2,815		20	141	141	564	13
14	SECURITY CAMERA SYSTEM	2008	12,685		20	634	634	2,536	14
15	ELECTRIC LOCKS, SWITCHES	2008	5,961		20	298	298	1,192	15
16	ROOFING	2008	117,096		20	5,855	5,855	23,420	16
17	ELECTRICAL	2008	5,068		20	253	253	1,012	17
18	EXHAUST FAN SYSTEM/FIRE DAMPER	2008	16,200		20	810	810	3,240	18
19	REHAB MASTER BATH	2008	19,560		20	978	978	3,912	19
20	DOOR & FRAME	2008	3,096		20	155	155	620	20
21	EJECTOR PUMP	2008	7,629		20	381	381	1,524	21
22	SIDEWALKS	2008	12,420		20	621	621	2,484	22
23	ROOFING	2008	114,800		20	5,740	5,740	22,960	23
24	DOORS & FRAMES	2008	14,980		20	749	749	2,996	24
25	REBUILD WALL	2008	3,300		20	165	165	660	25
26	REHAB MASTER BATH	2008	10,644		20	532	532	2,128	26
27	WINDOWS	2008	18,972		20	949	949	3,796	27
28	FIRE SPRINKLER SYSTEM	2009	58,790		20	2,940	2,940	8,820	28
29	PUMP-HYDRO PNEUMATIC TANK	2009	14,759		20	738	738	2,214	29
30	WATER MAIN	2009	21,100		20	1,055	1,055	3,165	30
31	SHOWER ROOMS #2 AND #3-Walls, Tiles, Electrical, Paint	2009	11,602		20	580	580	1,740	31
32	RENOVATE ROOMS-Ceiling, Paint, Flooring/Tiles, Electrical	2009	73,641		20	3,682	3,682	11,046	32
33	REBUILD DINING ROOM WALLS	2009	3,558		20	178	178	534	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Riviera Care Center

0049940

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	EMERGENCY GENERATOR	2009	69,472		20	3,474	3,474	10,422	2
3	REBUILD DINING ROOM WALLS	2009	3,558		20	178	178	534	3
4	SUPPLY/INSTALL COOLER/FREEZER	2009	23,450		20	1,173	1,173	3,519	4
5	PTAC's	2009	48,580		20	2,429	2,429	7,287	5
6	ENTRANCE DOOR LOCKS	2009	5,891		20	295	295	885	6
7	SLEEVES FOR PTAC	2009	4,724		20	236	236	708	7
8	INSTALL ROOM PTAC'S	2009	30,000		20	1,500	1,500	4,500	8
9	CURTAIN WALL REPLACEMENT	2009	27,200		20	1,360	1,360	4,080	9
10	WINDOW REPLACEMENT	2009	23,975		20	1,199	1,199	3,597	10
11	GENERATOR INSTALL	2009	4,952		20	248	248	744	11
12	INSTALL HOT WATER RECIRC. SYSTEM	2009	5,500		20	275	275	825	12
13	SUPPLY/INSTALL WATER HEATER	2009	8,920		20	446	446	1,338	13
14	DESIGN FIRE PROTECTION SYSTEM	2009	12,000		20	600	600	1,800	14
15	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	15
16	FIRE SPRINKLER SYSTEM	2009	109,181		20	5,459	5,459	10,918	16
17	ALARM SYSTEM	2010	62,230		20	3,112	3,112	6,224	17
18	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	18
19	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,730		20	187	187	374	19
20	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	20
21	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	21
22	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	22
23	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,730		20	187	187	374	23
24	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	24
25	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	324	25
26	ALARM SYSTEM	2010	8,778		20	439	439	878	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,105,185	\$		\$ 55,267	\$ 55,267	\$ 177,446	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	73,498	2,186		1,885	(301)	2,748	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	3,501	350	20	350		446	9
10	Allocated from 8131 N. Monticello	2010	32,923	3,292	20	1,646	(1,646)	2,532	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 109,922	\$ 5,828		\$ 3,881	\$ (1,947)	\$ 5,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 567,489	\$ 1,087	\$ 95,077	\$ 93,990	10	\$ 269,465	71
72	Current Year Purchases	23,809	84	3,954	3,870	10	4,043	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 591,298	\$ 1,171	\$ 99,031	\$ 97,860		\$ 273,508	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		CHRYSLER VAN	2009	\$ 10,320	\$	\$ 1,705	\$ 1,705	5	\$ 6,697	76
77		09' GMAC SAVANA	2009	37,763		6,188	6,188	5	15,075	77
78		Allocated from YAM Manager	2011	2,858	316	316		5	107	78
79										79
80	TOTALS			\$ 50,941	\$ 316	\$ 8,209	\$ 7,893		\$ 21,879	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 6,513,518	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 297,511	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 298,626	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,115	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 916,163	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated From YAM management							5
6								6
7	TOTAL				\$			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$840
- Description: See Attached Schedule

(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	Facility	Volkswagen	\$485.00	\$5,825	17
18	Allocated from YAM Management			1,923	18
19	Allocated from YAM Consulting			6,581	19
20					20
21	TOTAL		\$485.00	\$14,329	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,000	\$ 29,490	1
2	Cash-Patient Deposits	6,660	6,660	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,256,350	2,256,350	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,443	86,443	6
7	Other Prepaid Expenses	2,100	2,100	7
8	Accounts Receivable (owners or related parties)	58,000	1,228,149	8
9	Other(specify): See Attached Schedule	60,192	210,153	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,471,745	\$ 3,819,345	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		813,733	13
14	Buildings, at Historical Cost		2,124,302	14
15	Leasehold Improvements, at Historical Cost	345,188	1,613,288	15
16	Equipment, at Historical Cost	422,155	747,468	16
17	Accumulated Depreciation (book methods)	(193,720)	(791,504)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,767,653	2,825,668	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,341,276	\$ 7,332,955	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,813,021	\$ 11,152,300	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 378,394	\$ 378,395	26
27	Officer's Accounts Payable	(20,000)	(20,000)	27
28	Accounts Payable-Patient Deposits	17,270	17,270	28
29	Short-Term Notes Payable	1,082,051	1,151,496	29
30	Accrued Salaries Payable	140,489	140,489	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,189	51,189	31
32	Accrued Real Estate Taxes(Sch.IX-B)		385,000	32
33	Accrued Interest Payable	6,520	42,902	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,395,168	201,774	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,051,081	\$ 2,348,515	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,224,999	39
40	Mortgage Payable		6,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,724,999	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,051,081	\$ 10,073,514	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,761,940	\$ 1,078,786	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,813,021	\$ 11,152,300	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,521,122	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,521,122	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	736,588	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	(495,770)	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)	\$ 240,818	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,761,940	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,218,345	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,218,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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	See Supplemental Schedule	2,516	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,516	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,220,861	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,089,352	31
32	Health Care	2,148,673	32
33	General Administration	1,608,363	33
	B. Capital Expense		
34	Ownership	1,142,094	34
	C. Ancillary Expense		
35	Special Cost Centers	386,291	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,484,273	40
41	Income before Income Taxes (line 30 minus line 40)**	736,588	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 736,588	43

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

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

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

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

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	1,343	1,495	\$ 57,846	\$ 38.69	1
2	Assistant Director of Nursing	2,044	2,229	68,384	30.68	2
3	Registered Nurses	2,428	2,483	69,130	27.84	3
4	Licensed Practical Nurses	28,098	29,658	776,975	26.20	4
5	CNAs & Orderlies	45,522	48,605	479,374	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	19,390	19,995	191,244	9.56	8
9	Activity Director	1,993	2,086	33,704	16.16	9
10	Activity Assistants	7,806	8,125	72,651	8.94	10
11	Social Service Workers	11,040	11,835	202,298	17.09	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,086	52,143	25.00	13
14	Head Cook	3,603	3,758	41,924	11.16	14
15	Cook Helpers/Assistants	12,136	12,827	121,457	9.47	15
16	Dishwashers					16
17	Maintenance Workers	4,652	4,781	79,046	16.53	17
18	Housekeepers	15,209	16,041	158,474	9.88	18
19	Laundry	3,446	3,679	32,207	8.75	19
20	Administrator	2,218	2,331	95,256	40.86	20
21	Assistant Administrator	2,503	2,857	44,869	15.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,421	8,472	124,869	14.74	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	1,897	2,102	29,142	13.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,009	3,206	79,511	24.80	33
34	TOTAL (lines 1 - 33)	177,799	188,651	\$ 2,810,504 *	\$ 14.90	34

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	289	\$ 13,585	01-03	35
36	Medical Director	Monthly	19,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,182	59,100	10-03	38
39	Pharmacist Consultant	Monthly	8,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	5	240	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,792	11-03	44
45	Social Service Consultant	73	4,152	12-03	45
46	Other(specify)				46
47	Dietary Consultant	Monthly	800	01-03	47
48					48
49	TOTAL (lines 35 - 48)	1,585	\$ 107,669		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Riviera Care Center		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21	
				# 0049940				Ending:		12/31/11	
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Heather Bassett		Administrator	0	\$ 95,256	Workers' Compensation Insurance		\$ 193,426	IDPH License Fee		\$	
Scott Sklar (8/3/2009-6/30/2011)		Asst Admin	0	31,792	Unemployment Compensation Insurance		143,723	Advertising: Employee Recruitment		4,341	
Moshe Freedman (8/29/11-current)		Asst Admin	0	13,077	FICA Taxes		207,160	Health Care Worker Background Check		12,510	
					Employee Health Insurance		58,522	(Indicate # of checks performed 1251)			
					Employee Meals		23,543	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Licenses & Permits		4,349	
					Union Pension Expense		698	Dues & Subscriptions		16,634	
					Employee Benefits- Other		3,382	Allocated from 8131 N. Monticello		66	
					Life Insurance		5,546	Allocated from YAM Consulting		90	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 140,125							
B. Administrative - Other											
Description				Amount							
Management Fees - David Berkowitz				\$ 24,000							
Management Fees - Yosef Meystel				15,000							
Administrative Consulting- YAM Consulting				7,800							
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 46,800							
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount	
YAM Management		Bookkeeping/Accounting	\$ 145,500				\$	Out-of-State Travel		\$	
ADAR		Data Processing	3,833								
YAM Management		Data Processing	1,454								
FR&R		Accounting	36,250					In-State Travel			
Personnel Planners		Unemployment Consulting	4,436								
See Attached		Legal Fees	16,175								
E-Health Data Solutions		Data Processing	4,901								
HDSI		Data Processing	3,950					Seminar Expense		2,939	
American Data		Data Processing	7,299					Allocated from YAM Consulting		410	
Various		Data Processing	1,168					Allocated from YAM Management		1,079	
Blymas, Inc.		Tax Credit Services	4,280								
See Supplemental Schedule			25,533					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)							\$	(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 254,779				TOTAL		\$ 4,428	
* Attach copy of IMRF notifications											
SEE ACCOUNTANTS' COMPILATION REPORT											
**See instructions.											

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. ILCLTC \$19,800

(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? N/A

(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? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,479 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(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. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500
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. \$ 23,543 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(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. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14

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. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT