

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0049528</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>RIVERSHORES CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</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>578 W COMMERCIAL ST</u> <u>MARSEILLES</u> <u>61341</u>																									
Number City Zip Code																									
County: <u>LASALLE</u>																									
Telephone Number: <u>(815) 795-5121</u> Fax # <u>(815) 795-4929</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>5/1/07</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>PAMELA PHILLIPS</u> Telephone Number: <u>(417) 865-8701</u>																									
Email Address: _____																									

Facility Name & ID Number RIVERSHORES CARE CENTER# 0049528 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,698</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>103</u>	TOTALS	<u>103</u>	<u>37,698</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	<u>17,961</u>		<u>4,916</u>	<u>22,877</u>	8
9	SNF/PED					9
10	ICF		<u>3,435</u>		<u>3,435</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,961</u>	<u>3,435</u>	<u>4,916</u>	<u>26,312</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.80%

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)

N/A

F. Does the facility maintain a daily midnight census?

YESG. 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 5/1/07

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date 5/1/07NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 103 and days of care provided 4,534Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

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	174,739	15,471	9,964	200,174		200,174		200,174			1
2	Food Purchase		170,547		170,547		170,547	(2,907)	167,640			2
3	Housekeeping	97,565	14,441		112,006		112,006		112,006			3
4	Laundry	44,082	13,670		57,752		57,752		57,752			4
5	Heat and Other Utilities			118,605	118,605		118,605	1,277	119,882			5
6	Maintenance	45,607		66,082	111,689		111,689	1,922	113,611			6
7	Other (specify):*											7
8	TOTAL General Services	361,993	214,129	194,651	770,773		770,773	292	771,065			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,442,950	109,208	7,449	1,559,607		1,559,607		1,559,607			10
10a	Therapy	593,168	946	226,433	820,547		820,547		820,547			10a
11	Activities	87,669	8,959	12,482	109,110		109,110		109,110			11
12	Social Services	29,951		5,184	35,135		35,135		35,135			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,153,738	119,113	263,548	2,536,399		2,536,399		2,536,399			16
	C. General Administration											
17	Administrative	90,002		130,917	220,919		220,919	(122,789)	98,130			17
18	Directors Fees											18
19	Professional Services			282,432	282,432		282,432	(17,601)	264,831			19
20	Dues, Fees, Subscriptions & Promotions			39,774	39,774		39,774	(11,645)	28,129			20
21	Clerical & General Office Expenses	127,953	41,876	96,138	265,967		265,967	32,305	298,272			21
22	Employee Benefits & Payroll Taxes			536,560	536,560		536,560		536,560			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,562	9,562		9,562	227	9,789			24
25	Other Admin. Staff Transportation			42,782	42,782		42,782	1,707	44,489			25
26	Insurance-Prop.Liab.Malpractice			86,146	86,146		86,146	331	86,477			26
27	Other (specify):*							9,034	9,034			27
28	TOTAL General Administration	217,955	41,876	1,224,311	1,484,142		1,484,142	(108,431)	1,375,711			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,733,686	375,118	1,682,510	4,791,314		4,791,314	(108,139)	4,683,175			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			224	224		224	93,374	93,598			30
31	Amortization of Pre-Op. & Org.							61	61			31
32	Interest			36,109	36,109		36,109	293,399	329,508			32
33	Real Estate Taxes			43,462	43,462		43,462	504	43,966			33
34	Rent-Facility & Grounds			264,000	264,000		264,000	(263,844)	156			34
35	Rent-Equipment & Vehicles			49,514	49,514		49,514	536	50,050			35
36	Other (specify):*							97,341	97,341			36
37	TOTAL Ownership			393,309	393,309		393,309	221,371	614,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			288,063	288,063		288,063		288,063			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,788	285,788		285,788		285,788			42
43	Other (specify):*							(22,019)	(22,019)			43
44	TOTAL Special Cost Centers			573,851	573,851		573,851	(22,019)	551,832			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,733,686	375,118	2,649,670	5,758,474		5,758,474	91,213	5,849,687			45

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

	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	(2,862)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(231)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	2		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	(110)	21		18
19	Entertainment				19
20	Contributions	(2,775)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,957)	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	(44,583)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,563)		\$	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)	153,776		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 153,776		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 91,213		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

STATE OF ILLINOIS
RIVERSHORES CARE CENTER

ID# 0049528
Report Period Beginning: 1/1/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	VENDING INCOME	(2,020)	21	2
3	MISCELLANEOUS INCOME	(15)	21	3
4	TAXES - GENERAL	(306)	21	4
5	MARKETING SALARIES	(18,406)	43	5
6	MARKETING EMPLOYEE BENEFITS	(3,613)	43	6
7	ADJUST SL DEPR	(1,723)	30	7
8	DIALYSIS	(18,500)	19	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	(44,583)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/12 Ending: 12/31/12
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,907)	0	0	0	0	0	0	0	0	0	0	(2,907)	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	1,277	0	0	0	0	0	0	0	0	1,277	5
6	Maintenance	0	0	1,922	0	0	0	0	0	0	0	0	1,922	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,907)	0	3,199	0	0	0	0	0	0	0	0	292	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	(122,789)	0	0	0	0	0	0	0	0	(122,789)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,500)	(3,255)	4,154	0	0	0	0	0	0	0	0	(17,601)	19
20	Fees, Subscriptions & Promotions	(11,957)	0	312	0	0	0	0	0	0	0	0	(11,645)	20
21	Clerical & General Office Expenses	(5,226)	0	37,531	0	0	0	0	0	0	0	0	32,305	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	227	0	0	0	0	0	0	0	0	227	24
25	Other Admin. Staff Transportation	0	0	1,707	0	0	0	0	0	0	0	0	1,707	25
26	Insurance-Prop.Liab.Malpractice	0	0	331	0	0	0	0	0	0	0	0	331	26
27	Other (specify):*	0	0	9,034	0	0	0	0	0	0	0	0	9,034	27
28	TOTAL General Administration	(35,683)	(3,255)	(69,493)	0	0	0	0	0	0	0	0	(108,431)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,590)	(3,255)	(66,294)	0	0	0	0	0	0	0	0	(108,139)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,723)	93,403	1,694	0	0	0	0	0	0	0	0	93,374	30
31	Amortization of Pre-Op. & Org.	0	0	61	0	0	0	0	0	0	0	0	61	31
32	Interest	(231)	292,765	865	0	0	0	0	0	0	0	0	293,399	32
33	Real Estate Taxes	0	0	504	0	0	0	0	0	0	0	0	504	33
34	Rent-Facility & Grounds	0	(264,000)	156	0	0	0	0	0	0	0	0	(263,844)	34
35	Rent-Equipment & Vehicles	0	0	536	0	0	0	0	0	0	0	0	536	35
36	Other (specify):*	0	97,341	0	0	0	0	0	0	0	0	0	97,341	36
37	TOTAL Ownership	(1,954)	219,509	3,816	0	0	0	0	0	0	0	0	221,371	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):*	(22,019)	0	0	0	0	0	0	0	0	0	0	(22,019)	43
44	TOTAL Special Cost Centers	(22,019)	0	0	0	0	0	0	0	0	0	0	(22,019)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(62,563)	216,254	(62,478)	0	0	0	0	0	0	0	0	91,213	45

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 PG6-SUPP				

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	RENTAL INCOME	\$ 264,000	PHRS REALTY, LLC		\$	\$ (264,000)	1
2	V	30	DEPRECIATION				93,403	93,403	2
3	V	32	INTEREST				292,765	292,765	3
4	V	36	AMORTIZATION-LOAN COSTS				97,341	97,341	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	133,200	PHC CONSULTANTS, LLC		129,945	(3,255)	8
9	V								9
10	V	19	PROFESSIONAL FEES	886	MTS CONSULTING		886		10
11	V								11
12	V								12
13	V								13
14	Total			\$ 398,086			\$ 614,340	\$ * 216,254	14

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

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	17	HOME OFFICE	\$ 130,917	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (130,917)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,277	1,277	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		1,922	1,922	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		8,128	8,128	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		4,154	4,154	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		312	312	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		34,354	34,354	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		3,177	3,177	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		227	227	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		1,707	1,707	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		331	331	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		9,034	9,034	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,169	1,169	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		536	536	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		61	61	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		525	525	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		865	865	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		504	504	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		156	156	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 130,917			\$ 68,439	\$ * (62,478)	39

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

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	BEN KLEIN	4.34	ALL FAITH PAVILION	CHICAGO	PLATINUM HEALTH	SKOKIE, IL	MANAGEMENT	1
2	BEREKE TRUST	51.5	BELLA VISTA CARE CENTER	PEORIA HEIGHTS	CARE, LLC			2
3	BRIAN LEVINSON	30.83	CAPITOL CARE CENTER	SPRINGFIELD	PHRS REALTY, LLC		BUILDING	3
4	MARK SHAPIRO	13.33	COLONIAL HALL CARE CENTER	PRINCETON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5			MORTON TERRACE CARE CENTER	MORTON	MTS CONSULTING	SKOKIE	CONSULTING	5
6			MORTON VILLA CARE CENTER	MORTON				6
7			RIVER VALLEY SUPPORTING LVG RES	KANKAKEE				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

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	BEN KLEIN		Administrative	4.34	SEE ATTACHED	2	3.85	Mgt Fees	\$		1
2	BRIAN LEVINSON		Administrative	30.83	SEE ATTACHED	4	10.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	13.33	SEE ATTACHED	4	10.00	Mgt Fees			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

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 PLATINUM HEALTH CARE, LLC
Street Address 7444 LONG AVENUE
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 329-4100
Fax Number (847) 329-7652

	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	5	Utilities	Patient Days	923,219	30	\$ 44,791	\$	26,312	\$ 1,277	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		26,312	1,922	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	26,312	8,128	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		26,312	4,154	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		26,312	312	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	26,312	34,354	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		26,312	3,177	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		26,312	227	8
9	25	Travel	Patient Days	923,219	30	59,896		26,312	1,707	9
10	26	Insurance	Patient Days	923,219	30	11,602		26,312	331	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		26,312	9,034	11
12	30	Depreciation	Patient Days	923,219	30	40,988		26,312	1,169	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		26,312	536	13
14	31	Amortization	Patient Days	923,219	30	2,134		26,312	61	14
15	30	Depreciation	Patient Days	923,219	30	18,405		26,312	525	15
16	32	Interest	Patient Days	923,219	30	30,356		26,312	865	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		26,312	504	17
18	34	Office Rent	Patient Days	923,219	30	5,488		26,312	156	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,401,289	\$ 1,490,552		\$ 68,439	25

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			X	MORTGAGE			\$					\$	292,765	1
2														2
3														3
4														4
5														5
	Working Capital													
6	OXFORD FINANCE		X	LINE OF CREDIT									36,109	6
7														7
8														8
9	TOTAL Facility Related						\$					\$	328,874	9
	B. Non-Facility Related*													
10	INTEREST INCOME OFFSET												(231)	10
11														11
12														12
13	ALLOCATION FROM PLATINUM HEALTH CARE												865	13
14	TOTAL Non-Facility Related						\$					\$	634	14
15	TOTALS (line 9+line14)						\$					\$	329,508	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 32

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$		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.)		\$	46,079	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	46,079	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$	46,079	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	42,915	8	
		2008	45,392	9	
		2009	45,618	10	
		2010	46,221	11	
		2011	46,079	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
RIVERSHORES CARE CENTER
COUNTY
LASALLE

FACILITY IDPH LICENSE NUMBER
0049528

CONTACT PERSON REGARDING THIS REPORT
PAMELA PHILLIPS

TELEPHONE
(417) 865-8701
FAX #:
(417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 15-49-325-027	Long Term Care Property	\$ 45,454.80	\$ 45,454.80
2. 15-49-325-026	Long Term Care Property	\$ 624.16	\$ 624.16
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 46,078.96	\$ 46,078.96

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? YES X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:	26,830	B. General Construction Type:	Exterior	BRICK	Frame	MASONRY	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).

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			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number RIVERSHORES CARE CENTER

0049528

Report Period Beginning:

1/1/12

Ending:

12/31/12

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			2007		\$ 1,215,400	\$ 44,196	27.5	\$ 44,196	\$	\$ 228,348	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			2007	6,326		10	633	633	3,268	9
10	CONCRETE SLAB, SIDEWALK			2007	2,840		15	189	189	947	10
11	RENOVATE SHOWER ROOM-A.M REMODELING-CONTRACT			2008	4,500		27.5	164	164	805	11
12	MAT/LAB-INSTALL LAUNDRY ROOM BOILER-AL'S PLUMBING &			2008	4,883		20	244	244	1,221	12
13	INSTALL WATER HEATER-AL'S PLUMBING & HEATING			2008	5,228		10	523	523	2,570	13
14	HOYER POWER LIFTER (MOVE TO EQUIP-2009 DESK AUDIT)			2008	3,464		10				14
15	PLASTER NORTH & EAST WALL-VILLAS CONCRETE			2008	10,000		27.5	364	364	1,758	15
16	NEW HOLDING TANK FOR BOILER			2008	3,000		20	150	150	713	16
17	REBUILD DISHWASHER-HOBART SERV (REMOVED CAP DESK A			2008			10				17
18	INSTALL COMPRESSOR FOR KITCHEN A/C-MUCCI & KIRPATRICK			2008			10				18
19	CLEANED & SANITIZED ICE MACHINE--MUCCI & KIRKPATRICK			2008			10				19
20	REPLACE CONCRETE--S&E CONCRETE (REMOVED CAP DESK A			2008			15				20
21	WATER HEATER			2009	5,500		10	550	550	2,200	21
22	MEDICAL ROOM DOOR & FRAME (REMOVED CAP DESK AUDIT			2009			15				22
23	GENERATOR			2009	8,085		5	1,617	1,617	6,468	23
24	ELECTRICAL WORK			2009	16,169		20	808	808	3,099	24
25	DRYWALL WORK (REMOVED CAP DESK AUDIT 2009)			2009			5				25
26	PAINT & REPAIR WALLS (REMOVED CAP DESK AUDIT 2009)			2009			5				26
27	FIRE DAMPER (REMOVED CAP DESK AUDIT 2009)			2009			20				27
28	NEW DOOR & FRAME (REMOVED CAP DESK AUDIT 2009)			2009			15				28
29	RESURFACE PARKING LOT			2009	42,000		8	5,250	5,250	18,813	29
30	CONCRETE WORK			2009	3,500		15	233	233	856	30
31	CONCRETE WORK (REMOVED CAP DESK AUDIT 2009)			2009			15				31
32	KITCHEN DUCT WORK (REMOVED CAP DESK AUD 2009			2009			20				32
33	CONCRETE WORK (REMOVED CAP DESK AUDIT 2009)			2009			15				33
34	4 RESIDENT ROOM REMODEL -CONTRACT-A.M. REMODELERS			2011	10,276		10	1,028	1,028	1,884	34
35	SPRINKLER SYSTEM			2011	78,200		25	3,128	3,128	3,649	35
36	ROOF			2011	71,669		27.5	2,606		3,692	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

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			\$	\$		\$	\$	\$	37
38	WATER SERVICE FOR SPRINKLERS	2011	16,912		25	676	676	846	38
39									39
40	FIRE SPRINKLER SYSTEM	2012	17,630		25	411	411	411	40
41	POWER SUPPLY/TESTING FIRE ALARM SYSTEM	2012	2,937		5	440	440	440	41
42	SOFFITS FOR SPRINKLER SYSTEM	2012	8,200		20	239	239	239	42
43	THERAPY ROOM REMODEL-CONTRACT-AM REMODELER	2012	17,850		15	595	595	595	43
44	THERAPY ROOM REMODEL-CONTRACT-AM REMODELER	2012	8,325		10	416	416	416	44
45	SPRINKLER SYSTEM	2012	7,448		25	174	174	174	45
46	PLUMBING	2012	6,600		20	165	165	165	46
47				23,402			(23,402)		47
48									48
49									49
50									50
51									51
52									52
53	SHOWER ROOM REMODELING-CONTRACT-A.M. REMODE	2010	6,150	224	27.5	224		578	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65	ALLOCATION FROM PLATINUM HEALTH CARE			375		375			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,583,092	\$ 68,197		\$ 65,398	\$ (5,405)	\$ 284,155	70

**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	\$ 277,956	\$ 25,476	\$ 26,552	\$ 1,076		\$ 133,340	71
72	Current Year Purchases	7,177	329	329			329	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM HC		1,319	1,319				74
75	TOTALS	\$ 285,133	\$ 27,124	\$ 28,200	\$ 1,076		\$ 133,669	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)	\$ 1,868,225	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,321	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,598	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,723)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 417,824	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 49,514
- Description: Med equip 15,385; Rehab equip 15,600; Printer/copier 16,546; Postage 948; Dish machine 1,035
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$	849	\$ 50,933	\$	849	\$ 50,933	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		1,061	71,431		1,061	71,431	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		1,726	103,530		1,726	103,530	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				285,719		285,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Therapist</u>	10a-03				539			539	12
13	Other (specify): <u>Lab & X-ray</u>	39-02					2,344		2,344	13
14	TOTAL			\$	3,636	\$ 226,433	\$ 288,063	3,636	\$ 514,496	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 83,169	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,464,433		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,369		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,646,971	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,150		15
16	Equipment, at Historical Cost	12,766		16
17	Accumulated Depreciation (book methods)	(18,916)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,646,971	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 723,065	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,821		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	56,428		36
37	Due Others	758,552		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,605,866	\$	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)	\$ 1,605,866	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 41,105	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,646,971	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (166,718)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (166,718)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	207,823	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)	\$ 207,823	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)	\$ 41,105	24 *

* This must agree with page 17, line 47.

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 4,066,043	1	
2 Discounts and Allowances for all Levels	(379,829)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,686,214	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	2,023,399	6	
7 Oxygen	922	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,024,321	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	2,862	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	235,760	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory	14,510	19	
20 Radiology and X-Ray	225	20	
21 Other Medical Services		21	
22 Laundry	139	22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 253,496	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	231	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 231	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 VENDING/MISC INCOME	2,035	28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,035	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,966,297	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	770,773	31	
32 Health Care	2,536,399	32	
33 General Administration	1,484,142	33	
B. Capital Expense			
34 Ownership	393,309	34	
C. Ancillary Expense			
35 Special Cost Centers	288,063	35	
36 Provider Participation Fee	285,788	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,758,474	40	
41 Income before Income Taxes (line 30 minus line 40)**	207,823	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 207,823	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 2,683,504	44	
45 Private Pay - Net Inpatient Revenue	554,686	45	
46 Medicare - Net Inpatient Revenue	505,627	46	
47 Other-(specify) <u>Managed Care</u>	82,023	47	
48 Other-(specify) <u>Part B, Bad Debts, Prior Year Adj</u>	(139,626)	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,686,214	49	

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN FILED ON CASH BASIS
*** 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,103	2,317	\$ 77,343	\$ 33.38	1
2	Assistant Director of Nursing	1,008	1,056	30,956	29.31	2
3	Registered Nurses	12,244	13,089	337,767	25.81	3
4	Licensed Practical Nurses	14,522	14,960	339,912	22.72	4
5	CNAs & Orderlies	52,382	54,358	622,810	11.46	5
6	CNA Trainees					6
7	Licensed Therapist	6,553	6,668	375,533	56.32	7
8	Rehab/Therapy Aides	9,302	10,056	217,635	21.64	8
9	Activity Director	2,072	2,351	49,009	20.85	9
10	Activity Assistants	4,683	4,959	38,660	7.80	10
11	Social Service Workers	1,727	1,904	29,951	15.73	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,080	28,000	13.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,670	15,290	146,739	9.60	15
16	Dishwashers					16
17	Maintenance Workers	2,440	2,565	45,607	17.78	17
18	Housekeepers	10,955	11,465	97,565	8.51	18
19	Laundry	4,384	4,590	44,082	9.60	19
20	Administrator	1,944	2,080	90,002	43.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,163	8,739	127,953	14.64	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	2,791	3,073	34,162	11.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,847	161,600	\$ 2,733,686 *	\$ 16.92	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	184	\$ 8,820	1.3	35
36	Medical Director	Monthly	12,000	9.3	36
37	Medical Records Consultant	Quarterly	1,840	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant		5,609	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,448	11.3	44
45	Social Service Consultant	84	5,184	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	317	\$ 35,901		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number# 0049528

Report Period Beginning: 1/1/12

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Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GERALD MERTES III	ADMINISTRATOR		\$ 90,002
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,002

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		\$ 282,432
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 282,432

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 182,904	
Unemployment Compensation Insurance	51,651	
FICA Taxes	202,064	
Employee Health Insurance	85,643	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
401K	200	
EMPLOYEE BENEFITS - OTHER	10,309	
EMPLOYEE PHYSICAL EXAM	3,789	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 536,560

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	3,399	
Health Care Worker Background Check (Indicate # of checks performed 24)	3,562	
Patient Background Checks	251	
ADVERTISING & MARKETING	11,957	
DUES & SUBSCRIPTIONS	15,904	
LICENSES	4,952	
ALLOCATION FROM PLATINUM	312	
Less: Public Relations Expense	()	
Non-allowable advertising	(11,957)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 28,129

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	9,562
ALLOCATION FROM PLATINUM	227
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 9,789

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. IL COUNCIL LTC \$11,495

(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? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,475 Line 10.2

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 285,788
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? N/A 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? _____
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?
g. Does the facility transport residents to and from day training? _____
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) 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.