

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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.

<p>I. IDPH Facility ID Number: <u>0041178</u></p> <p>Facility Name: <u>Riverview, A Senior Living Community</u></p> <p>Address: <u>500 Centennial Dr.</u> <u>East Peoria</u> <u>61611</u> <small>Number City Zip Code</small></p> <p>County: <u>Tazwell</u></p> <p>Telephone Number: <u>(309) 694 - 0022</u> Fax # <u>(309) 694 - 3655</u></p> <p>IDPA ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10 / 03 / 95</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Dekany, Reimb. Manager</u> Telephone Number: <u>(419) 252 - 5740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06 / 01 / 99</u> to <u>05 / 31 / 00</u> and certify to the best of my knowledge and belief that the said content 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</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td></td> <td>(Title) <u>VP of Reimbursement</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Barry Lazarus</u>		(Title) <u>VP of Reimbursement</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Firm Name & Address) _____																																						
	(Telephone) <u>()</u> Fax # <u>()</u>																																						

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Riverview, A Senior Living Community

0041178 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

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	55	Skilled (SNF)	55		1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	55		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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	53	549	3,278	3,880	8
9	SNF/PED					9
10	ICF	658	13,201	417	14,276	10
11	ICF/DD					11
12	SC		268		268	12
13	DD 16 OR LESS					13
14	TOTALS	711	14,018	3,695	18,424	14

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

D. How many bed-hold days during this year were paid by Public Aid? 4 (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? Yes

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

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

I. On what date did you start providing long term care at this location?
Date started 10 / 03 / 95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10 / 03 / 95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 3246

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCUAL MODIFIED CASH* CASH*

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

Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

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

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00
 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	115,130	7,583	1,527	124,240	1,374	125,614	546	126,160		1
2	Food Purchase		133,057		133,057		133,057	0	133,057		2
3	Housekeeping	68,495	6,881		75,376		75,376	0	75,376		3
4	Laundry	24,191	14,536		38,727		38,727	(77)	38,650		4
5	Heat and Other Utilities			53,531	53,531	5,122	58,653	0	58,653		5
6	Maintenance	17,787	13,233	14,521	45,541		45,541	0	45,541		6
7	Other (specify):*			2,403	2,403		2,403	0	2,403		7
8	TOTAL General Services	225,603	175,290	71,982	472,875	6,496	479,371	469	479,840		8
	B. Health Care and Programs										
9	Medical Director			5,900	5,900		5,900	0	5,900		9
10	Nursing and Medical Records	689,963	87,284	84,582	861,829	6,934	868,763	0	868,763		10
10a	Therapy	128,621	1,438	19,681	149,740		149,740	0	149,740		10a
11	Activities	30,094	1,386	973	32,453		32,453	0	32,453		11
12	Social Services	19,539	372	1,962	21,873	269	22,142	0	22,142		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	868,217	90,480	113,098	1,071,795	7,203	1,078,998		1,078,998		16
	C. General Administration										
17	Administrative	59,042		111,198	170,240	(21,439)	148,801	0	148,801		17
18	Directors Fees							0			18
19	Professional Services			1,681	1,681	(1,681)		0			19
20	Dues, Fees, Subscriptions & Promotions			36,912	36,912		36,912	(11,026)	25,886		20
21	Clerical & General Office Expenses	63,069	(25,292)	69,607	107,384		107,384	(55,098)	52,286		21
22	Employee Benefits & Payroll Taxes			221,876	221,876	577	222,453	0	222,453		22
23	Inservice Training & Education			2,093	2,093		2,093	0	2,093		23
24	Travel and Seminar			9,859	9,859		9,859	0	9,859		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			41,846	41,846		41,846	0	41,846		26
27	Other (specify):*							0			27
28	TOTAL General Administration	122,111	(25,292)	495,072	591,891	(22,543)	569,348	(66,124)	503,224		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,215,931	240,478	680,152	2,136,561	(8,844)	2,127,717	(65,655)	2,062,062		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

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			161,974	161,974	8,844	170,818	0	170,818		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			200,690	200,690		200,690	(1,044)	199,646		32
33	Real Estate Taxes			77,981	77,981		77,981	0	77,981		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			6,954	6,954		6,954	0	6,954		35
36	Other (specify):*							0			36
37	TOTAL Ownership			447,599	447,599	8,844	456,443	(1,044)	455,399		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		53,236	6,549	59,785		59,785	0	59,785		39
40	Barber and Beauty Shops		16,726		16,726		16,726	0	16,726		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			30,196	30,196		30,196	0	30,196		42
43	Other (specify):*		259		259		259	0	259		43
44	TOTAL Special Cost Centers		70,221	36,745	106,966		106,966		106,966		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,215,931	310,699	1,164,496	2,691,126	0	2,691,126	(66,699)	2,624,427		45

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

Print Preview

x

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 15 / 31 / 00

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	546	1		4
5	Telephone, TV & Radio in Resident Rooms	(2,114)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(77)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,044)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,938)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,580)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,466)	21		24
25	Fund Raising, Advertising and Promotional	(11,026)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,699)		\$	30

OHF USE ONLY						
48		49	50	51	52	

Print Preview

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (66,699)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number Riverview, A Senior Living Community

0041178 Report Period Beginning:

06 / 01 / 99

Ending:

Summary A

05 / 31 / 00

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

Print Summary		Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
		A. General Services													
1		Dietary	546	0	0	0	0	0	0	0	0	0	0	546	1
2		Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3		Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4		Laundry	(77)	0	0	0	0	0	0	0	0	0	0	(77)	4
5		Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6		Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8		TOTAL General Services	469	0	0	0	0	0	0	0	0	0	0	469	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		Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14		Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16		TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
		C. General Administration													
17		Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18		Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19		Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20		Fees, Subscriptions & Promotions	(11,026)	0	0	0	0	0	0	0	0	0	0	(11,026)	20
21		Clerical & General Office Expenses	(55,098)	0	0	0	0	0	0	0	0	0	0	(55,098)	21
22		Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23		Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24		Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25		Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26		Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28		TOTAL General Administration	(66,124)	0	0	0	0	0	0	0	0	0	0	(66,124)	28
		TOTAL Operating Expense													
29		(sum of lines 8,16 & 28)	(65,655)	0	0	0	0	0	0	0	0	0	0	(65,655)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

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

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,044)	0	0	0	0	0	0	0	0	0	0	(1,044)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,044)	0	0	0	0	0	0	0	0	0	0	(1,044)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,699)	0	0	0	0	0	0	0	0	0	0	(66,699)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THIS WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: Waukegan, 10001 State: IL Report Period Beginning: 01/01/19 Ending: 01/31/19

VI. RELATED PARTIES: Show Pys A through C Show Pys A through C Show Pys A through C

7. Enter below the names of ALL owners and related organizations (as defined in the instructions). Attach an additional schedule if necessary.

OWNERS		RELATIONSHIP ENTITY		OTHER RELATED ORGANIZATIONS	
Name	Ownership %	Name	City	Name	City
<u>Waukegan, Ill</u>	<u>100</u>	<u>Waukegan, Ill</u>	<u>Waukegan, Ill</u>		

8. For any costs included in this report which are a result of transactions with related organizations (as defined in the instructions), this includes cost management fees, purchase of supplies, and so forth.

If any costs incurred as a result of transactions with related organizations must be fully detailed in accordance with the instructions for determining costs as provided by this form.

Schedule V	Line	Item	Account	Name of Related Organization	Period of Charges	Organization Code	Reference to Related Organization Code/ID Number
V	1	<u>Supplies</u>	<u>311.100</u>	<u>Ill. State</u>	<u>01/01/19</u>	<u>000000</u>	<u>000000</u>
V	2						
V	3						
V	4						
V	5						
V	6						
V	7						
V	8						
V	9						
V	10						
V	11						
V	12						
V	13						
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V	96						
V	97						
V	98						
V	99						
V	100						

Print Preview

1. Enter the information on pages 5 and 5A.
 2. For pages 6 thru 48, the information you enter does not need to be sorted by line reference.
 3. For pages 6 thru 48, a line can be referenced as many times as needed per page.
 4. For pages 6 thru 48, related organizations costs for therapy must be referenced as line number 10.
 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6

Line 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43

VII. RELATED PARTIES (continued)

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

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

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

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

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

Print Previe

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 5 / 31 / 00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

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

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252 - 5500
 Fax Number (419) 254 - 5494

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost 100,182,693	357 Nurs. Fac.	\$ 388,478	\$ 221,496	111,198	\$ 431	1
2	5	Utilities	Accumulated Cost 100,182,693	357 Nurs. Fac.	4,614,666		111,198	5,122	2
3	10	Nursing	Accumulated Cost 100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	111,198	6,934	3
4	17	General & Administrative	Accumulated Cost 100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	111,198	89,289	4
5	22	Employee Benefits	Accumulated Cost 100,182,693	357 Nurs. Fac.	520,233		111,198	577	5
6	30	Depreciation	Accumulated Cost 100,182,693	357 Nurs. Fac.	7,968,019		111,198	8,844	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				\$ 100,182,694	\$ 31,146,197		\$ 111,197	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		8	9	10		
						Amount of Note						
						Original	Balance					
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
	YES	NO										
A. Directly Facility Related												
Long-Term												
1	Bankers Trust Co.		X	Facility			\$ 8,925,000	\$ 8,925,000			\$ 200,298	1
2												2
3												3
4												4
5												5
Working Capital												
6												6
7								Interest Income Offset			(1,044)	7
8								Interest Expense Other			392	8
9	TOTAL Facility Related						\$ 8,925,000	\$ 8,925,000			\$ 199,646	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 8,925,000	\$ 8,925,000			\$ 199,646	15

* 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.)

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,156 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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	<u>Facility</u>		<u>1995</u>	<u>\$ 335,515</u>	1
2					2
3	TOTALS			\$ 335,515	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Riverview, A Senior Living Community

0041178

Report Period Beginning:

06 / 01 / 99 Ending:

05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59		1995		\$ 2,170,148	\$ 55,800		\$ 55,800	\$	\$ 254,903	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		Current Year Depreciation				23,417		23,417		48,932	9
10		FLOORING/CARPETING		1997	2,228						10
11		ELECTRICAL		1997	4,089						11
12		KICKPLATES		1997	2,838						12
13		HOT WATER TANK		1997	2,744						13
14		FLOORING		1997	1,825						14
15		MOTOR		1997	2,305						15
16		GAZEBO IMPROVEMENTS		1997	1,737						16
17		WALL COVERING		1997	5,337						17
18		ROOM UPGRADES		1997	37,321						18
19		SIGNS		1997	1,179						19
20		STEAMER		1997	2,587						20
21		ROOFING		1998	1,117						21
22		FLOORING		1998	4,963						22
23		CARPENTRY		1998	3,150						23
24		PLUMBING		1998	10,659						24
25		WALLCOVERING		1998	9,932						25
26		DOOR/WINDOW		1998	658						26
27		RENOVATION		1998	41,798						27
28		FINISH /STUD		1998	4,351						28
29		CARPENTRY		1998	4,953						29
30		DOOR/WINDOW		1998	14,573						30
31		FLOORING		1998	6,859						31
32		PLUMBING		1998	757						32
33		ELECTRICAL		1998	7,844						33
34		PAINTING/WALLCOVERING		1998	12,790						34
35		GENERAL CONTRACTOR FEES		1998	11,007						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 79,217		\$ 79,217	\$	\$ 303,835	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0041178

Report Period Beginning:

06 / 01 / 99 Ending:

Page 12A

05 / 31 / 00

Facility Name & ID Number Riverview, A Senior Living Community

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		ROOFING		1998	500						9
10		SIGNAGE		1998	28,202						10
11		HVAC		1998	4,530						11
12		CONCRETE SIDEWALK		1998	1,800						12
13		PAINTING/WALLCOVERING		1999	460						13
14		DINING ROOM REMODEL		1999	3,196						14
15		WALLCOVERING		2000	47						15
16		WALLCOVERING		2000	148						16
17		WALLCOVERING		2000	417						17
18		DOUBLE EGRESS DOORS		2000	2,985						18
19		JOCKEY PUMP FOR SPRINKER SYSTEM		2000	310						19
20		OFFICE REMODELING		2000	660						20
21		DINING RENOVATIONS		2000	2,169						21
22		OFFICE RENO		2000	3,064						22
23		CIRCULATING PUMP & PIPING		2000	2,814						23
24		DINING ROOM REMODELING COST		2000	540						24
25		WALLCOVERING		2000	1,689						25
26		PIPING		2000	998						26
27		PIPING COST		2000	22						27
28		ADDTL PIPING COST		2000	274						28
29		PIPING COST		2000	2,475						29
30		PIPING		2000	33,529						30
31		ADDTL COST OFFICE RENOVATION		2000	231						31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0041178

Report Period Beginning:

Page 12B
06 / 01 / 99 Ending: 05 / 31 / 00

Facility Name & ID Number Riverview, A Senior Living Community

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
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16											16
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

Facility Name & ID Number Riverview, A Senior Living Community # 0041178 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 552,075	\$ 82,756	\$ 82,756	\$ 0		\$ 304,475	37
38	Current Year Purchases	25,150						38
39	Fully Depreciated Assets							39
40	Home Office			8,844	8,844			40
41	TOTALS	\$ 577,225	\$ 82,756	\$ 91,601	\$ 8,845		\$ 304,475	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	N/A			\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 161,973	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 170,818	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 8,845	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 608,310	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	N/A	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	\$ 8,729	58
59			59
60			60
61	TOTALS	\$ 8,729	61

* 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.

Print Previe

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	1 2 3 4			
	Facility		Contract	Total
	Drop-outs	Completed		
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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Print Preview

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units					
					Units	Cost				
1	Licensed Occupational Therapist	10a	2,377 hrs	\$ 56,431		\$ 3,923	\$ 437	2,377	\$ 60,791	1
2	Licensed Speech and Language Development Therapist	10a	409 hrs	13,995		3,668	17	409	17,680	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2,763 hrs	58,195		7,330	984	2,763	66,509	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts			4,760	53,236		57,996	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Inhalation & Lab</u>	39,3				6,549			6,549	13
14	TOTAL			\$ 128,621		\$ 26,230	\$ 54,674	5,549	\$ 209,525	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 nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Riverview, A Senior Living Community

0041178

Report Period Beginning: 06 / 01 / 99

Ending:

05 / 31 / 00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05 / 31 / 00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 10,799		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,256)	140,264		3
4	Supply Inventory (priced at)	8,525		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,551		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 161,139	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	337,315		13
14	Buildings, at Historical Cost	2,459,008		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	577,226		16
17	Accumulated Depreciation (book methods)	(608,309)		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): CIP	8,729		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,773,969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,935,108	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 22,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,845		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,781		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,208		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			36
37	Other Accrued Liabilities	26,357		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 207,345	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 207,345	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,727,763	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,935,108	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,026,638	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,026,638	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(6,597)	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)	\$ (6,597)	17
B. Transfers (Itemize):			
18	INTERDIVISION	1,707,722	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,707,722	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,727,763	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Riverview, A Senior Living Community

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Report Period Beginning: 06 / 01 / 99

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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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,457,738	1
2	Discounts and Allowances for all Levels	(261,216)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,196,522	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	405,054	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 405,054	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,580	12
13	Barber and Beauty Care	14,952	13
14	Non-Patient Meals	(546)	14
15	Telephone, Television and Radio	2,114	15
16	Rental of Facility Space		16
17	Sale of Drugs	54,602	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,124	19
20	Radiology and X-Ray		20
21	Other Medical Services	6	21
22	Laundry	77	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 81,909	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,044	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,044	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,684,529	30

2		3	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 472,875	31
32	Health Care	1,071,795	32
33	General Administration	591,891	33
B. Capital Expense			
34	Ownership	447,599	34
C. Ancillary Expense			
35	Special Cost Centers	106,966	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,691,126	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,597)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,597)	43

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

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

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

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

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Facility Name & ID Number Riverview, A Senior Living Community

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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	2,168	5,012	\$ 87,716	\$ 17.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,028	9,558	133,751	13.99	3
4	Licensed Practical Nurses	8,052	9,464	128,953	13.63	4
5	Nurse Aides & Orderlies	30,029	32,869	309,885	9.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,276	6,747	74,898	11.10	7
8	Rehab/Therapy Aides	4,232	4,693	53,723	11.45	8
9	Activity Director					9
10	Activity Assistants	2,516	2,770	30,094	10.86	10
11	Social Service Workers	1,691	1,824	19,539	10.71	11
12	Dietician	12,265	14,050	115,130	8.19	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,191	1,277	17,787	13.93	17
18	Housekeepers	8,402	9,780	68,495	7.00	18
19	Laundry	2,433	2,792	24,191	8.66	19
20	Administrator	1,998	2,080	59,042	28.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,000	5,046	63,069	12.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,444	1,645	29,658	18.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,725	109,607	\$ 1,215,931 *	\$ 11.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 943	1,5	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	269	12,5	45
46	Other(specify) <u>Administrative</u>	Monthly	469	17,5	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,681		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,153	\$ 16,148	10,3	50
51	Licensed Practical Nurses	2,058	28,047	10,3	51
52	Nurse Aides	3,368	31,056	10,3	52
53	TOTAL (lines 50 - 52)	6,579	\$ 75,251		53

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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								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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13													
14													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Facility Name & ID Number Riverview, A Senior Living Community

0041178

Report Period Beginning: 06 / 01 / 99

Ending: 05 / 31 / 00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA 2232
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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. \$ 24,567 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,196
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 of Public Aid, 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? NO
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.