

Facility Name RIVER VALLEY SUPPORTIVE LIVING RESIDENCE LLC

Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	62	Single Unit Apartment	62	22,630	1
2	18	Double Unit Apartment	18	6,570	2
3		Other		6,570	3
4	80	TOTALS	80	35,770	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	19,382	1,175		20,557	5
6	Double Unit	7,973	392		8,365	6
7	Other					7
8	TOTALS	27,355	1,567		28,922	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 80.86%

D. Indicate the number of paid bed-hold days the SLF had during this year
 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: Fiscal Year:

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

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IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	146,422	167,405	2,325	316,152		316,152	1
2	Housekeeping, Laundry and Maintenance	103,908	65,349	13,145	182,402		182,402	2
3	Heat and Other Utilities			78,994	78,994		78,994	3
4	Other (specify):							4
5	TOTAL General Services	250,330	232,754	94,464	577,548		577,548	5
B. Health Care and Programs								
6	Health Care/ Personal Care	270,036	6,554	3,042	279,632		279,632	6
7	Activities and Social Services	27,879	6,178		34,057		34,057	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	297,915	12,732	3,042	313,689		313,689	9
C. General Administration								
10	Administrative and Clerical	210,870	15,352	366,316	592,538	(73,015)	519,523	10
11	Marketing Materials, Promotions and Advertising		20,397	45,799	66,196		66,196	11
12	Employee Benefits and Payroll Taxes			119,897	119,897		119,897	12
13	Insurance-Property, Liability and Malpractice			29,456	29,456		29,456	13
14	Other (specify):							14
15	TOTAL General Administration	210,870	35,749	561,468	808,087	(73,015)	735,072	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	759,115	281,235	658,974	1,699,324	(73,015)	1,626,309	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest			58,727	58,727		58,727	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			408,000	408,000		408,000	20
21	Rent -- Equipment			10,851	10,851		10,851	21
22	Other (specify): AMORT/BAD DEBTS			152,277	152,277		152,277	22
23	TOTAL Ownership			629,855	629,855		629,855	23
24	GRAND TOTAL (Sum of lines 16 and 23)	759,115	281,235	1,288,829	2,329,179	(73,015)	2,256,164	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 39.83	1
2	Licensed Practical Nurses	3	19.66	2
3	Certified Nurse Assistants	16	8.90	3
4	Activity Director & Assistants	2	12.43	4
5	Social Service Workers	11	8.71	5
6	Head Cook	3	8.33	6
7	Cook Helpers/Assistants	12	7.93	7
8	Dishwashers			8
9	Maintenance Workers	1	11.79	9
10	Housekeepers	8	7.18	10
11	Laundry	1	13.87	11
12	Managers	1	15.77	12
13	Other Administrative	1	13.87	13
14	Clerical	5	13.87	14
15	Marketing	1	13.87	15
16	Other			16
17	Total (lines 1 thru 16)	66	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	BEN KLEIN	ATTACHED		\$ 106,944	1
2	BRIAN LEVINSON			106,944	2
3					3
4					4
5					5
Total				\$ 213,888	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES	
Name <u>1</u>	City <u>2</u>
ATTACHED	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
ATTACHED		

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: PLATINUM HEALTH CARE LLC If yes, what is the value of those services? \$ 92,491

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

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VIII. OWNERSHIP COSTS

A. Purchase price of land 55,470 Year land was acquired 2003

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

*Total units on this schedule must agree with page 2.

	1 Units*	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	
1	80		2003		\$ 3,800,347	\$ 138,195	28	\$ 131,317	\$ (6,878)	\$ 285,199	1
2											2
3											3
4											4
5											5
Improvement Type											
6		DOORS, LOCKS & DOOR HOLDERS		2004	6,801	250	28	250		362	6
7		HANDICAP TOILETS		2004	1,073	37	28	37		57	7
8		ROOF REPAIRS		2004	2,900	104	28	104		152	8
9		WATER RETAINER KIT		2004	666	25	28	25		36	9
10		WATER HEATER REPAIR		2005	5,708	96	28	96		96	10
11		ROOF REPAIRS		2005	8,800	145	28	145		145	11
12		DRYWALL & PAINTING		2005	4,780	78	28	78		78	12
13		ELEVATOR REPAIR		2005	1,982	35	28	35		35	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,833,057	\$ 138,965		\$ 132,087	\$ (6,878)	\$ 286,160	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 106,575	\$ 13,344	\$ 10,658	(2,686)	10	\$ 20,460	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 106,575	\$ 13,344	\$ 10,658	(2,686)		\$ 20,460	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

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

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	LASALLE BANK		X	MORTGAGE	/ /	\$ 3,520,000	\$ 3,382,500	/ /		\$ 213,336
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 3,520,000	\$ 3,382,500			\$ 213,336
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 3,520,000	\$ 3,382,500			\$ 213,336

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

STATE OF ILLINOIS

Facility Name: RIVER VALLEY SUPPORTIVE LIVING RESIDENCE LLC

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,268	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	581,710		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,863		6
7	Other Prepaid Expenses	400		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 641,241	\$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	534,730		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(242,158)		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)	\$ 292,572	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 933,813	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 297,000	\$	26
27	Officer's Accounts Payable	1,045,286		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	8,111		30
31	Accrued Taxes Payable	7,629		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,708,026	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
Other Long-Term Liabilities(specify):				
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,708,026	\$	45
46	TOTAL EQUITY	\$ (774,213)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 933,813	\$	47

*(See instructions.)

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,126,947	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,126,947	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	FOOD STAMP REVENUE	71,716	15
16	PHONE/CABLE REVENUE	29,094	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 100,810	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,227,757	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	577,548	19
20	Health Care/ Personal Care	313,689	20
21	General Administration	808,087	21
B. Capital Expense			
22	Ownership	629,855	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,329,179	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (101,422)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (101,422)	31

RIVER VALLEY SUPPORTIVE LIVING RESIDENCE
RELATED ORGANIZATIONS
PAGE 4 SCHEDULE VII C

RENT	-408000
DEPRECIATION	152309
INTEREST	217394
REAL ESTATE TAXES	87524

PAGE 4 SCHEDULE VII B

RELATED PARTY EXP	-44000
UTILITIES	2646
REPAIRS & MAINTENANCE	2669
ADMINISTRATIVE SALARY	24141
PROFESSIONAL FEES	2090
FEES, SUBSCRIPTIONS	646
OFFICE	40099
EDUCATION & SEMINARS	161
TRAVEL	1284
EMPLOYEE BENEFITS	11333
INSURANCE	465
DEPRECIATION	682
OFFICE RENT	6275
TOTAL	92491