

		FOR OFF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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 Facility ID Number:** 0012955

**Facility Name:** PROPHETS RIVERVIEW

**Address:** 310 MOSHER DRIVE PROPHETSTOWN 61277  
 Number City Zip Code

**County:** WHITESIDE

**Telephone Number:** (815) 537-5175 **Fax #** (815) 537-2628

**IDPA ID Number:** 45-0228055

**Date of Initial License for Current Owners:** \_\_\_\_\_

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input 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 _____	

**In the event there are further questions about this report, please contact:**  
**Name:** KIM KOURI **Telephone Number:** (605) 362-3178

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>RAYE NAE NYLANDER</u>	
	(Title) <u>VICE PRESIDENT/CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PROPHETS RIVERVIEW# 0012955 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

## 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>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,250</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>70</u>	TOTALS	<u>70</u>	<u>25,550</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>10,776</u>	<u>9,943</u>	<u>2,040</u>	<u>22,759</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,776</u>	<u>9,943</u>	<u>2,040</u>	<u>22,759</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.08%

D. How many bed-hold days during this year were paid by the Department?

1 (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)

OUTPATIENT THERAPYF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 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 9/20/1967

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

YES  Date \_\_\_\_\_ NO 

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary CAHABA

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number      **PROPHETS RIVERVIEW**      #      **0012955**      Report Period Beginning:      **1/1/2005**      Ending:      **12/31/2005**

**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	
	<b>A. General Services</b>											
1	Dietary	192,724	9,714	5,876	208,314		208,314	(156)	208,158			1
2	Food Purchase		127,286		127,286		127,286	(13,276)	114,010			2
3	Housekeeping	57,511	14,327		71,838		71,838	(251)	71,587			3
4	Laundry	53,371	11,640		65,011		65,011	(221)	64,790			4
5	Heat and Other Utilities			83,151	83,151		83,151		83,151			5
6	Maintenance	67,794	5,365	37,308	110,467		110,467	(5,292)	105,175			6
7	Other (specify):*			10,739	10,739		10,739	(410)	10,329			7
8	<b>TOTAL General Services</b>	<b>371,400</b>	<b>168,332</b>	<b>137,074</b>	<b>676,806</b>		<b>676,806</b>	<b>(19,606)</b>	<b>657,200</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	960,673	143,267	13,484	1,117,424		1,117,424	(78,089)	1,039,335			10
10a	Therapy		1,410	219,729	221,139		221,139	(97,217)	123,922			10a
11	Activities	67,050	2,113	8,941	78,104		78,104	(6,326)	71,778			11
12	Social Services	32,579	266	1,081	33,926		33,926	(5)	33,921			12
13	CNA Training											13
14	Program Transportation			2,996	2,996		2,996		2,996			14
15	Other (specify):*	33,397			33,397		33,397		33,397			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,093,699</b>	<b>147,056</b>	<b>246,231</b>	<b>1,486,986</b>		<b>1,486,986</b>	<b>(181,637)</b>	<b>1,305,349</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	58,094		122,579	180,673		180,673	10,156	190,829			17
18	Directors Fees											18
19	Professional Services			2,146	2,146		2,146		2,146			19
20	Dues, Fees, Subscriptions & Promotions			14,932	14,932		14,932	(9,526)	5,406			20
21	Clerical & General Office Expenses	104,856	11,025	34,299	150,180		150,180	(1,380)	148,800			21
22	Employee Benefits & Payroll Taxes			332,787	332,787		332,787	(5,822)	326,965			22
23	Inservice Training & Education			6,495	6,495		6,495	(10)	6,485			23
24	Travel and Seminar			1,264	1,264		1,264	(1,036)	228			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,959	32,959		32,959	3,574	36,533			26
27	Other (specify):* <b>Res Dev</b>			11,318	11,318		11,318	(11,318)				27
28	<b>TOTAL General Administration</b>	<b>162,950</b>	<b>11,025</b>	<b>558,779</b>	<b>732,754</b>		<b>732,754</b>	<b>(15,362)</b>	<b>717,392</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,628,049</b>	<b>326,413</b>	<b>942,084</b>	<b>2,896,546</b>		<b>2,896,546</b>	<b>(216,605)</b>	<b>2,679,941</b>			<b>29</b>

\*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.

Facility Name & ID Number PROPHETS RIVERVIEW #0012955 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	<b>D. Ownership</b>										
30	Depreciation			163,373	163,373	163,373		163,373			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			304	304	304	(304)				32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,622	3,622	3,622		3,622			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			167,299	167,299	167,299	(304)	166,995			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		166	2,529	2,695	2,695	(2,695)				40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,272	38,272	38,272		38,272			42
43	Other (specify):*			4,726	4,726	4,726	(4,726)				43
44	<b>TOTAL Special Cost Centers</b>		166	45,527	45,693	45,693	(7,421)	38,272			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,628,049	326,579	1,154,910	3,109,538	3,109,538	(224,330)	2,885,208			45

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

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

**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	(13,276)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,210)	11		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				10
11	Discounts, Allowances, Rebates & Refunds	2,066	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,596)	6		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				24
25	Fund Raising, Advertising and Promotional	(9,526)	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	(199,696)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (232,238)		\$	30

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)	7,908		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 7,908		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (224,330)		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.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

**PROPHETS RIVERVIEW**ID# 0012955Report Period Beginning: 1/1/2005Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	UNIFORM	\$ (983)	21	1
2	WANDERGUARD	(1,600)	21	2
3	RESIDENT SUPPLIES	(410)	7	3
4	INT INC PAST DUE ACCTS	(3)	21	4
5	P/F INT EXP - NC	(304)	32	5
6	ACTIVITY	(76)	11	6
7	DEFERRED MAINT - 2005	353	6	7
8	BANK CHARGES	(164)	21	8
9	COLLECTION AGENCY FEES	(417)	21	9
10	PRESCR DRUGS - REIMB	(69,969)	10	10
11	BARBER/BEAUTY EXPENSES	(2,695)	40	11
12	SUPPLIES - RES DEV	(148)	21	12
13	MISC FUNDRAISER EXP	(759)	27	13
14	MED SUPPLIES - PT B	(6,657)	10	14
15	NEWSLETTER - RES DEV	(645)	27	15
16	STAFF DEV - RES DEV	(10)	23	16
17	POSTAGE - RES DEV	(198)	27	17
18	TRAVEL - RES DEV	(27)	24	18
19	CONTRACT SERVICES - RES DEV	(650)	27	19
20	C/SERV - SHARED EMP - RES DEV	(9,066)	27	20
21	OUT OF STATE TRAVEL	(1,009)	24	21
22	THERAPY OFFSET - PT, OT, ST	(97,208)	10A	22
23	P/SERV - EKG	(439)	43	23
24	P/SERV - LAB	(1,920)	43	24
25	P/SERV - RADIOLOGY	(2,327)	43	25
26	LAB FEES	(40)	43	26
27	PHARM-INNOC-RES	(259)	10	27
28	DISCOUNT ALLOW - ADMIN	(131)	21	28
29	DISCOUNT ALLOW - NURSING	(1,193)	10	29
30	DISCOUNT ALLOW - THERAPY	(9)	10A	30
31	DISCOUNT ALLOW - HIM	-11	10	31
32	DISCOUNT ALLOW - ACTIVITIES	-40	11	32
33	DISCOUNT ALLOW - SOCIAL SERVICES	-5	12	33
34	DISCOUNT ALLOW - LAUNDRY	-221	4	34
35	DISCOUNT ALLOW - HOUSEKEEPING	-251	3	35
36	DISCOUNT ALLOW - DIETARY	-156	1	36
37	DISCOUNT ALLOW - OPER/MAINT	-49	6	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(199,696)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

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

	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)	
	<b>A. General Services</b>													
1	Dietary	(156)	0	0	0	0	0	0	0	0	0	0	(156)	1
2	Food Purchase	(13,276)	0	0	0	0	0	0	0	0	0	0	(13,276)	2
3	Housekeeping	(251)	0	0	0	0	0	0	0	0	0	0	(251)	3
4	Laundry	(221)	0	0	0	0	0	0	0	0	0	0	(221)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,292)	0	0	0	0	0	0	0	0	0	0	(5,292)	6
7	Other (specify):*	(410)	0	0	0	0	0	0	0	0	0	0	(410)	7
8	<b>TOTAL General Services</b>	<b>(19,606)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(19,606)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(78,089)	0	0	0	0	0	0	0	0	0	0	(78,089)	10
10a	Therapy	(97,217)	0	0	0	0	0	0	0	0	0	0	(97,217)	10a
11	Activities	(6,326)	0	0	0	0	0	0	0	0	0	0	(6,326)	11
12	Social Services	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	<b>TOTAL Health Care and Programs</b>	<b>(181,637)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(181,637)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	10,156	0	0	0	0	0	0	0	0	0	10,156	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	(9,526)	0	0	0	0	0	0	0	0	0	0	(9,526)	20
21	Clerical & General Office Expenses	(1,380)	0	0	0	0	0	0	0	0	0	0	(1,380)	21
22	Employee Benefits & Payroll Taxes	0	(5,822)	0	0	0	0	0	0	0	0	0	(5,822)	22
23	Inservice Training & Education	(10)	0	0	0	0	0	0	0	0	0	0	(10)	23
24	Travel and Seminar	(1,036)	0	0	0	0	0	0	0	0	0	0	(1,036)	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	3,574	0	0	0	0	0	0	0	0	0	3,574	26
27	Other (specify):*	(11,318)	0	0	0	0	0	0	0	0	0	0	(11,318)	27
28	<b>TOTAL General Administration</b>	<b>(23,270)</b>	<b>7,908</b>	<b>0</b>	<b>(15,362)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(224,513)</b>	<b>7,908</b>	<b>0</b>	<b>(216,605)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955

Report Period Beginning:

1/1/2005 Ending:

Summary B

12/31/2005

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	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	(304)	0	0	0	0	0	0	0	0	0	0	(304)	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	<b>TOTAL Ownership</b>	<b>(304)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(304)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(2,695)	0	0	0	0	0	0	0	0	0	0	(2,695)	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):*	(4,726)	0	0	0	0	0	0	0	0	0	0	(4,726)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(7,421)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,421)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(232,238)</b>	<b>7,908</b>	<b>0</b>	<b>(224,330)</b>	<b>45</b>								

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Evangelical Lutheran Good Samaritan Society 100</u>						

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	<u>17 Admin/Acctg</u>	\$ <u>122,579</u>	<u>The Evangelical Lutheran Good Samaritan Society</u>	<u>100.00%</u>	\$ <u>132,735</u>	\$ <u>10,156</u>	1
2	V	<u>22 Unemployment</u>						2
3	V	<u>22 Workers Comp</u>	<u>46,328</u>			<u>46,893</u>	<u>565</u>	3
4	V	<u>26 Insurance</u>	<u>32,959</u>			<u>36,533</u>	<u>3,574</u>	4
5	V	<u>22 Health Ins</u>	<u>133,789</u>			<u>127,402</u>	<u>(6,387)</u>	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ <u>335,655</u>			\$ <u>343,563</u>	\$ * <u>7,908</u>	14

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

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

## 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			NOT-APPLICABLE						\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955

Report Period Beginning:

1/1/2005

Ending:

2/31/2005

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NO ALLOCATION NECESSARY			\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	NOT APPLICABLE						\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15

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

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

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

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2000	_____	8		
2001	_____	9		
2002	_____	10		
2003	_____	11		
2004	_____	12		
			<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2004	\$		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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        NO

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955 Report Period Beginning:

1/1/2005 Ending:

12/31/2005

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,259 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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).

APARTMENTS - 4

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>1966</u>	<u>\$ 15,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 15,000</b>	3

Facility Name & ID Number **PROPHETS RIVERVIEW**

# **0012955**

Report Period Beginning:

1/1/2005

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**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			1967	1967	\$ 347,119	\$ 8,678	40	\$ 8,678		\$ 331,932	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Building										9
10											10
11				1973	669	17	40	17		538	11
12				1974	483	12	40	12		380	12
13				1975	31,653	791	varies	791		24,532	13
14				1977	4,676		20			4,676	14
15				1979	7,265		20			7,265	15
16				1980	2,114	9	varies	9		1,991	16
17				1981	58,599	1,404	varies	1,404		36,467	17
18				1982	8,455		varies			8,455	18
19				1983	14,821		varies			14,821	19
20				1984	8,772		varies			8,772	20
21				1985	25,345	138	varies	138		25,345	21
22				1986	7,033	15	varies	15		7,024	22
23				1987	78,081	3,616	varies	3,616		71,196	23
24				1988	48,071	1,127	varies	1,127		43,155	24
25				1989	102,492	21	varies	21		102,426	25
26				1990	922,005	41,301	varies	41,301		759,446	26
27				1991	5,729	168	varies	168		5,603	27
28				1992	24,955	535	varies	535		23,165	28
29				1993	11,809	282	varies	282		10,345	29
30				1994	45,574	959	varies	959		40,294	30
31				1995	31,371	849	varies	849		26,839	31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	1996	605	61	10	61		605	38
39	1996	784	39	20	39		392	39
40	1996	496	50	10	50		496	40
41	1996	205	14	15	14		136	41
42	1996	6,000	240	25	240		2,340	42
43	1996	5,497	550	10	550		5,451	43
44	1996	453	23	20	23		223	44
45	1996	365	18	20	18		176	45
46	1996	445	22	20	22		215	46
47	1996	7,100	473	15	473		4,497	47
48	1996	1,300	130	10	130		1,224	48
49	1996	600	40	15	40		377	49
50	1996	8,646		6			8,226	50
51	1996	2,857	143	20	143		1,345	51
52	1996	511		5			488	52
53	1996	420	28	15	28		261	53
54	1996	4,500	225	20	225		2,081	54
55	1997	590	39	15	39		347	55
56	1997	618	62	10	62		540	56
57	1997	378		5			378	57
58	1997	475	47	10	47		411	58
59	1997	1,286	129	10	129		1,104	59
60	1997	1,559	156	10	156		1,338	60
61	1997	1,800	180	10	180		1,545	61
62	1997	6,320	421	15	421		3,581	62
63	1997	1,000	67	15	67		567	63
64	1997	1,127	75	15	75		645	64
65	1997	2,000	200	10	200		1,683	65
66	1997	33,471	1,339	25	1,339		11,826	66
67	1997	504	25	20	25		223	67
68	1998	858	57	15	57		443	68
69	1998	2,326	155	15	155		1,202	69
70		\$ 1,882,187	\$ 64,929		\$ 64,929	\$	\$ 1,609,035	70

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

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**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,882,187	\$ 64,929		\$ 64,929	\$	\$ 1,609,035	1
2	<b>Building Continued</b>								2
3	Photo Electric Smoke Detector	1998	420	42	10	42		319	3
4	Lavatory Faucet With Pop Up	1998	362	18	20	18		139	4
5	Plastering Walls	1998	2,500		5			2,500	5
6	Labor Material for Wallpaper	1998	3,966	396	10	396		2,975	6
7	Wallpaper & Border-Dining Room	1998	1,529		5			1,529	7
8	Wallpaper & Border-Dining Room	1998	2,925		5			2,925	8
9	Material for Wall and Painting	1998	6,125		5			6,125	9
10	Toilet & Tank	1998	373	37	10	37		277	10
11	Dining Room and Doors Korogard	1998	5,925	395	15	395		2,929	11
12	Nurses Station	1998	6,401	427	5	427		3,094	12
13	Wallcovering	1998	5,209		5			5,209	13
14	Carpet 450 SQ Yards	1998	10,077		5			10,077	14
15	Material and Labor to Cable	1998	6,033	302	20	302		2,212	15
16	Staff Entrance Hall Flooring	1998	1,151		5			1,151	16
17	Plumbing Repair	1999	2,644	264	10	264		1,851	17
18	Carpet	1998	3,750		5			3,750	18
19	Door on 300 Wing	1999	600	40	15	40		280	19
20	Grease Trap	1999	626	63	10	63		438	20
21	Lavatory Faucets	1999	732	37	20	37		253	21
22	Entrance Door on 200 Wing	1999	600	40	15	40		270	22
23	Pulled Stool Flange	1999	443	44	10	44		299	23
24	Boiler	1999	694	69	10	69		464	24
25	Gutters Replacement	1999	8,260	826	10	826		5,438	25
26	Rebuilt Corner/Overh. Porch	1999	560	56	10	56		364	26
27	Faucets	1999	1,070	54	20	54		348	27
28	Toilet Tanks	1999	1,628	81	20	81		529	28
29	Water Heater	2000	4,981	498	10	498		2,947	29
30	Flooring	2000	1,338	156	5	156		1,338	30
31	AM Standard Faucets	2000	953	48	20	48		260	31
32	Generator Repair	2000	966	97	10	97		515	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,965,028	\$ 68,919		\$ 68,919	\$	\$ 1,669,839	34

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

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

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**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,965,028	\$ 68,919		\$ 68,919	\$	\$ 1,669,839	1
2	<b>Building Continued</b>								2
3	Vinyl Floor Finish-Resident Rm	2000	7,427	743	10	743		3,773	3
4	Vinyl Flooring	2001	477	48	10	48		239	4
5	Lockset	2001	1,314	88	15	88		438	5
6	Door Locks	2001	1,825	122	15	122		608	6
7	Toilet	2001	353	18	20	18		85	7
8	Fire Alarm Panel	2001	395	25	15	25		142	8
9	Carpet For Wing Halls	2001	13,485	2,697	5	2,697		13,036	9
10	Carpet for Chapel & Hallway	2001	5,820	1,164	5	1,164		5,529	10
11	Toilets	2001	353	18	20	18		85	11
12	Air conditioner	2001	708	142	5	142		661	12
13	Wall Unit, Panels, Priv Screen	2001	968	65	5	65		285	13
14	Ceiling for dining Room	2001	1,394	93	15	93		395	14
15	Ventilation	2001	143,372	9,558	15	9,558		38,233	15
16	Corner Guards-Resident room	2001	162	16	10	16		66	16
17	Doors-Resident Room	2001	1,770	118	15	118		482	17
18	Duct Work-Resident Room	2001	2,139	107	20	107		437	18
19	AC For Beauty Shop	2001	329	66	5	66		307	19
20	Interior Partitions-Resid RM	2001	844	56	15	56		230	20
21	Paint-Resident room Remodel	2001	181	36	5	36		148	21
22	Corner Guards-Resident room	2001	558	56	10	56		228	22
23	Wallpaper-Resident Room Remode	2001	6,694	1,339	5	1,339		5,466	23
24	Carpet	2002	1,107	221	5	221		830	24
25	Blinds-Remodel 8 Rms	2002	217	43	5	43		134	25
26	Building-Remodel 8 Rms	2002	924	37	25	37		114	26
27	Corner Guards-Remodel 8 Rms	2002	139	14	10	14		43	27
28	Drapes-Remodel 8 Rms	2002	14	3	5	3		9	28
29	Duct Work-Remodel 8 Rms	2002	1,115	56	20	56		172	29
30	Plumbing-Remodel 8 Rms	2002	354	24	15	24		73	30
31	Shades	2002	364	73	5	73		224	31
32	Garage/Storage building	2003	60,774	4,052	15	4,052		12,155	32
33	Cabinet, Window-Kitchen	2002	1,726	173	10	173		619	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,222,330	\$ 90,190		\$ 90,190	\$	\$ 1,755,084	34

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

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,222,330	\$ 90,190		\$ 90,190	\$	\$ 1,755,084	1
2	<b>Buildings Continued</b>								2
3	Water Softner	2002	6,291	629	10	629		1,887	3
4	Dietary Entrance Door	2003	1,960	131	15	131		283	4
5	Dining Room counter Top & Base	2003	509	34	15	34		102	5
6	Toilet bowl, Tank, Sink	2004	1,694	85	20	85		136	6
7	Floor For Room 108	2004	1,897	190	10	190		332	7
8	Fire alarm System	2004	59,225	5,922	10	5,922		10,858	8
9	Wood Floor/Beauty Shop	2004	4,969	248	20	248		393	9
10	Fire Alarm Door	2004	556	28		28		32	10
11	Heritage Green Shutter	2005	936	62		62		62	11
12	Siemens Hipath 3750 Phone System	2005	20,546	1,027		1,027		1,027	12
13	Entrance Doors & Auto Openers	2005	8,319	35		35		35	13
14	Blinds-Remodel Resident Rooms	2005	138	2		2		2	14
15	Building-Remodel Resident Rooms	2005	17,662	147		147		147	15
16	Corner Guard-Rmdl Resident Rooms	2005	88	1		1		1	16
17	Paint-Rmdl Resident Rooms	2005	390	7		7		7	17
18	Wallpaper-Rmds Resident Rooms	2005	710	12		12		12	18
19	Resident Room Flooring	2005	58,123	3,391		3,391		3,391	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,406,343	\$ 102,141		\$ 102,141	\$	\$ 1,773,793	34

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

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 2,406,343	\$ 102,141		\$ 102,141	\$	\$ 1,773,793	1
2	Land Improvements								2
3									3
4	Cement	1991	461	31	15	31		445	4
5	sidewalks 1967	1967	1,223		15			1,223	5
6	Walks-Drives-Parking	1975	3,363		15			3,363	6
7	Blacktop Parking Lot	1978	2,250		15			2,250	7
8	Fence-Sears	1978	604		15			604	8
9	Parking Lot Paving	1979	2,940		15			2,940	9
10	Trees-Plants and Overall Lands	1981	2,147		10			2,147	10
11	Landscaping	1982	2,492		10			2,492	11
12	Trees	1983	850		10			850	12
13	landscaping	1983	400		10			400	13
14	Trees Shrubs	1990	560		10			560	14
15	Flowers/Topsoil/Rock For Lands	1990	858		10			858	15
16	Gate and Fence Construction	1991	726		10			707	16
17	New Outside Sign	1992	2,895		12			2,895	17
18	sidewalks	1992	1,200	80	15	80		1,080	18
19	Landscaping Around Sign	1992	536		10			536	19
20	Landscaping	1992	2,446		10			2,446	20
21	Concrete and Labor	1991	1,381	92	15	92		1,343	21
22	Field Survey & Peat Prep	1991	1,400		10			1,374	22
23	Blacktop Parking Lot	1993	428		10			428	23
24	Fence-Sears	1994	1,049	70	15	70		816	24
25	Landscaping For Front	1995	4,152	208	10	208		4,152	25
26	1 Coat of Sealer To Parking Lot	1995	1,500		5			1,500	26
27	Gazebo & Preparation	1996	3,234	162	20	162		1,563	27
28	Remove Existing Pavment	1997	7,843	392	20	392		3,301	28
29	Seal Coat Front Parking Lot	1997	2,500	250	10	250		2,104	29
30	Mulch Edging Fabric Weed	1998	582		5			582	30
31	Edging Pipedrain Elbow	1998	1,062	106	10	106		805	31
32	Gutter Screen Retaining Wall	1998	902	90	10	90		669	32
33	Perennial/Planting/Landscap	1999	1,726	155	10	155		949	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,460,053	\$ 103,776		\$ 103,776	\$	\$ 1,819,175	34

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

Facility Name & ID Number **PROPHETS RIVERVIEW**

# **0012955**

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12E, Carried Forward</b>	\$ 2,460,053	\$ 103,776		\$ 103,776	\$	\$ 1,819,175		1
2	<b>Land Improvements Cont'd</b>								2
3	Landscaping	2000 1,094	109	10	109		592		3
4	Parking Lot Overlay/Seal	2001 22,000	1,100	20	1,100		4,767		4
5	Landscaping-Memorial Gardens	2005 110,518	1,842	15	1,842		1,842		5
6	Trees-Memorial Gardens-Phase 1	2005 1,300	16	20	16		16		6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 2,594,965	\$ 106,843		\$ 106,843	\$	\$ 1,826,392		34

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

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	
71	Purchased in Prior Years	\$ 469,935	\$ 48,728	\$ 48,728	\$		\$ 265,107	71
72	Current Year Purchases	7,478	1,395	1,395			1,395	72
73	Fully Depreciated Assets	328,157	1,682	1,682			327,403	73
74			1,395	1,395				74
75	TOTALS	\$ 805,570	\$ 53,200	\$ 53,200	\$		\$ 593,905	75

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	
76	Resident Care	Van and License	1992	\$ 35,985	\$	\$	\$	4	\$ 35,985	76
77	Resident Care	2002 Olds MiniVan	2004	16,850	3,726	3,726		6	3,726	77
78		Disposal - 1988 Cadillac Brougham			(3,510)	(3,510)				78
79										79
80	TOTALS			\$ 52,835	\$ 216	\$ 216	\$		\$ 39,711	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)		\$ 3,468,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 160,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 160,259	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,460,008	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	Apartments Unit 40	\$	\$	\$	86
87	Building	65,102	2,448	51,170	87
88	FFE	8,528	166	8,113	88
89					89
90					90
91	TOTALS	\$ 73,630	\$ 2,614	\$ 59,283	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 130,004	92
93			93
94			94
95		\$ 130,004	95

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

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

Facility Name & ID Number PROPHETS RIVERVIEW

# 0012955

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

**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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 3,622      Description: Computer Equip Lease, Companion Reman Pump, Dishwasher

(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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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.)

	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	Ln 10a, Col 3	1278 hrs	\$ 79,541		\$	\$	1,278	\$ 79,541	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	468 hrs	35,701				468	35,701	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 3	1629 hrs	104,488				1,629	104,488	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 219,730		\$	\$	3,375	\$ 219,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**Report Period Beginning: **1/1/2005**

Ending:

**12/31/2005****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2005**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 93,511	\$	1
2	Cash-Patient Deposits	2,525		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	418,087		3
4	Supply Inventory (priced at )	13,559		4
5	Short-Term Investments	900,509		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,342		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,429,533	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,471,445		14
15	Leasehold Improvements, at Historical Cost	188,621		15
16	Equipment, at Historical Cost	866,933		16
17	Accumulated Depreciation (book methods)	(2,519,292)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	262,628		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>Asset Mgmt, CIP</b>	131,883		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,417,218	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,846,751	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 133,863	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,525		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,667		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,110		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
<b>Other Current Liabilities(specify):</b>				
36	<b>Group Ins</b>	(311)		36
37	<b>Security Deposits</b>	1,425		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 293,279	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 293,279	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,553,471	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,846,750	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,272,081	1
2	Restatements (describe):		2
3	<b>Apartments</b>	19,541	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,291,622	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	250,180	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) <b>Dnr Rst Prop/Oper Gft-cash</b>	50,490	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 300,670	17
<b>B. Transfers (Itemize):</b>			
18	<b>Cash Asset Assess-CO</b>	(38,821)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (38,821)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,553,471	24 *

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

Facility Name & ID Number PROPHETS RIVERVIEW# 0012955Report Period Beginning: 1/1/2005Ending: 12/31/2005**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,012,861	1
2	Discounts and Allowances for all Levels	(775,505)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,237,356	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	711,419	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 711,419	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	538	12
13	Barber and Beauty Care	2,457	13
14	Non-Patient Meals	13,276	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	154,943	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 171,276	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	100,833	24
25	Interest and Other Investment Income***	76,907	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 177,740	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Nsg &amp; Med Supplies</u>	40,963	28
28a	<u>Schedule Attached</u>	20,960	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 61,923	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,359,714	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	676,806	31
32	Health Care	1,486,986	32
33	General Administration	732,754	33
<b>B. Capital Expense</b>			
34	Ownership	167,299	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,421	35
36	Provider Participation Fee	38,272	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	(4)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,109,534	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	250,180	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 250,180	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.

Facility Name & ID Number **PROPHETS RIVERVIEW**

# **0012955**

Report Period Beginning: **1/1/2005**

Ending:

**12/31/2005**

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,886	2,192	\$ 50,963	\$ 23.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,510	3,851	75,890	19.71	3
4	Licensed Practical Nurses	12,313	13,611	216,509	15.91	4
5	CNAs & Orderlies	47,344	52,011	491,026	9.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,783	2,047	27,249	13.31	9
10	Activity Assistants	4,035	4,551	39,344	8.65	10
11	Social Service Workers	1,792	2,027	32,819	16.19	11
12	Dietician					12
13	Food Service Supervisor	1,829	2,070	28,447	13.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,364	17,188	163,873	9.53	15
16	Dishwashers					16
17	Maintenance Workers	4,750	5,350	68,380	12.78	17
18	Housekeepers	6,344	6,916	57,451	8.31	18
19	Laundry	5,963	6,424	52,489	8.17	19
20	Administrator	1,924	2,204	58,180	26.40	20
21	Assistant Administrator					21
22	Other Administrative	5,884	6,537	83,828	12.82	22
23	Office Manager	1,798	1,969	21,971	11.16	23
24	Clerical					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	1,777	2,061	25,259	12.26	31
32	Other Health Care(specify)	8,142	9,115	133,448	14.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,438	140,124	\$ 1,627,126 *	\$ 11.61	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	143	\$ 5,876	Ln 1, Col 3	35
36	Medical Director	104	3,350	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	2,640	Ln 10, Col 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	19	1,196	Ln 11, Col 3	44
45	Social Service Consultant	17	1,081	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	311	\$ 14,143		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



Facility Name & ID Number **PROPHETS RIVERVIEW**

Report Period Beginning: 1/1/2005 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Painting - 6 Restrooms	10/00	\$ 1,913	5	\$ 383	\$ 383	\$ 381	\$ 287	\$	\$	\$	\$	\$
2	Painting - Ceilings	2/01	51	5	10	10	10	10					
3	Painting	5/01	9	5	2	2	2	2					
4	Painting	6/01	8	5	2	2	2	1					
5	Painting	8/01	44	5	9	9	9	10					
6	Painting	8/01	31	5	6	6	6	8					
7	Painting	8/01	34	5	6	6	6	11					
8	Painting	9/01	48	5	9	9	9	16					
9	Painting	6/01	10	5	2	2	2	2					
10	Painting	9/01	17	5	4	4	4	3					
11	Painting	9/01	17	5	4	4	4	3					
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 2,182		\$ 437	\$ 437	\$ 435	\$ 353	\$	\$	\$	\$	\$

Facility Name &amp; ID Number PROPHETS RIVERVIEW

**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. Life Services Network, \$3617
- (3) Did the nursing home make political contributions or payments to a political action 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,140 Line 10, Col 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. \$ 38,273  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? YES Indicate the amount. \$ 13,276
- (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? 45%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- 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? 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? YES  
Firm Name: HENRY SCHOLTEN & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES 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.