

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 0022988

**Facility Name:** RIVERSIDE FOUNDATION

**Address:** 14588 WEST HIGHWAY 22 LINCOLNSHIRE 60069  
 Number City Zip Code

**County:** LAKE

**Telephone Number:** (847)634-3973 **Fax #** (847)634-0227

**HFS ID Number:** \_\_\_\_\_

**Date of Initial License for Current Owners:** 05-01-1976

**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:** HAROLD D. BLACKBURN CPA **Telephone Number:** (847) 251-1720

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07-01-2006 to 06-30-2007 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.

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ 10-18-2007  
 (Date)

(Type or Print Name) PETER MULE'

(Title) EXECUTIVE DIRECTOR

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date)

(Print Name and Title) HAROLD D. BLACKBURN  
CERTIFIED PUBLIC ACCOUNTANT

(Firm Name & Address) HAROLD D. BLACKBURN INC.  
1000 SKOKIE BLVD.LL-31 WILMETTE,IL,60091

(Telephone) (847)251-1720 Fax # (847)251-4705

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 RIVERSIDE FOUNDATION

# 0022988 Report Period Beginning: 07-01-2006 Ending: 06-30-2007

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>97</u>	Intermediate/DD	<u>97</u>	<u>35,405</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>35,191</u>	<u>0</u>	<u>0</u>	<u>35,191</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>35,191</u>			<u>35,191</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.40%

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

1,659 (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 05/01/1976

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

YES  Date DECEMBER 1993 NO

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

YES  NO  If YES, enter number of beds certified 97 and days of care provided 97

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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.

Facility Name & ID Number RIVERSIDE FOUNDATION # 0022988 Report Period Beginning: 07-01-2006 Ending: 06-30-2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	350,012	26,169	14,800	390,981		390,981	390,981			1
2	Food Purchase		243,162		243,162	36,474	279,636	279,636			2
3	Housekeeping	121,680	33,067		154,747		154,747	154,747			3
4	Laundry	41,592	2,791	51,402	95,785		95,785	95,785			4
5	Heat and Other Utilities			103,513	103,513		103,513	103,513			5
6	Maintenance	77,190	23,143	59,563	159,896		159,896	159,896			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	590,474	328,332	229,278	1,148,084	36,474	1,184,558	1,184,558			8
	<b>B. Health Care and Programs</b>										
9	Medical Director	30,000			30,000		30,000	30,000			9
10	Nursing and Medical Records	669,941	36,706	81,805	788,452		788,452	788,452			10
10a	Therapy										10a
11	Activities	1,152,532	10,850	123,756	1,287,138		1,287,138	1,287,138			11
12	Social Services	50,889		1,305	52,194		52,194	52,194			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,903,362	47,556	206,866	2,157,784		2,157,784	2,157,784			16
	<b>C. General Administration</b>										
17	Administrative	240,373		3,414	243,787		243,787	243,787			17
18	Directors Fees										18
19	Professional Services			80,110	80,110		80,110	80,110			19
20	Dues, Fees, Subscriptions & Promotions			9,857	9,857		9,857	9,857			20
21	Clerical & General Office Expenses	122,113	17,742		139,855		139,855	139,855			21
22	Employee Benefits & Payroll Taxes			605,103	605,103		605,103	605,103			22
23	Inservice Training & Education										23
24	Travel and Seminar			11,414	11,414		11,414	11,414			24
25	Other Admin. Staff Transportation			24,311	24,311		24,311	24,311			25
26	Insurance-Prop.Liab.Malpractice			56,533	56,533		56,533	56,533			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	362,486	17,742	790,742	1,170,970		1,170,970	1,170,970			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,856,322	393,630	1,226,886	4,476,838	36,474	4,513,312	4,513,312			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.

Facility Name & ID Number RIVERSIDE FOUNDATION

#0022988

Report Period Beginning: 07-01-2006 Ending: 06-30-2007

06-30-2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			102,592	102,592	102,592		102,592			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			60,963	60,963	60,963		60,963			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			163,555	163,555	163,555		163,555			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										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			259,302	259,302	259,302		259,302			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			259,302	259,302	259,302		259,302			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,856,322	393,630	1,649,743	4,899,695	36,474	4,936,169	4,936,169			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

\*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 RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2006

Ending: 06-30-2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	36,474	SCH 5		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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)				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				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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 36,474		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 36,474		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

BHF USE ONLY					
48		49		50	
				51	
					52

RIVERSIDE FOUNDATION

ID# 0022988

Report Period Beginning: 07-01-2006

Ending: 06-30-2007

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49





Facility Name & ID Number RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2006 Ending: 06-30-2007

**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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

RIVERSIDE FOUNDATION

#

0022988

Report Period Beginning:

07-01-2006

Ending:

06-30-2007

## 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									\$	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 RIVERSIDE FOUNDATION

# 0022988 Report Period Beginning: 07-01-2006 Ending: 6-30-2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	US BANK		X	REAL ESTATE MORTGAGE	\$11,071.00	08-10-03	\$ 1,400,000	\$ 1,144,375	08-10-03	0.0500	\$ 60,963	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>				\$11,071.00		\$ 1,400,000	\$ 1,144,375			\$ 60,963	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>						\$ 1,400,000	\$ 1,144,375			\$ 60,963	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 60,963 Line # 32

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME RIVERSIDE FOUNDATION COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0022988

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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number RIVERSIDE FOUNDATION

# 0022988 Report Period Beginning:

07-01-2006 Ending: 06-30-2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 30,000 B. General Construction Type: Exterior BRICK Frame FIRE RESISTANT Number of Stories ONE

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).

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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>CARE RELATED</u>	<u>135,000</u>	<u>1990</u>	<u>\$ 403,000</u>	1
2					2
3	<b>TOTALS</b>	<b>135,000</b>		<b>\$ 403,000</b>	<b>3</b>

Facility Name & ID Number **RIVERSIDE FOUNDATION**

# **0022988**

Report Period Beginning:

07-01-2006 Ending:

06-30-2007

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	97		1993	1976	\$ 1,602,278	\$ 53,409	30	\$ 53,409	\$	\$ 875,817	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9				2007	46,716	2,336	10	2,336		2,336	9
10		ELECTRICAL IMP. AND ENGINEERING COSTS		2006	45,858	4,586	10	4,586		6,879	10
11		ROOF IMP.,AC IMPROVEMENTS, & ELECTRICAL WORK		2005	124,119	12,412	10	12,412		37,236	11
12		NEW ROADS,FENCES,LANDSCAPING, & LIGHTING		2004	51,719	5,171	10	5,171		20,684	12
13		ENGINEERING FEES FOR ROADS & LANDSCAPING		2003	147,562	14,576	10	14,576		58,584	13
14		ARCHITECT FEES		2002	27,476	2,748	10	2,748		13,740	14
15		LAND ACQUISITION		2001	151,962						15
16		ELECTRICAL GENERATOR		2001	47,130	4,713	10	4,713		32,991	16
17		ELECTRICAL GENERATOR		2000	43,640	4,364	10	4,364		34,812	17
18		EXHAUST SYSTEM		1999	18,174	1,817	10	1,817		16,353	18
19		SUMP PUMP		1998	89,360	8,936	10	8,936		89,360	19
20		TV ANTENNA		1997	145,733					145,733	20
21		SHOWER ROOM		1996	57,631					57,631	21
22		PARKING LOT		1995	115,582					115,582	22
23		ELEVATOR		1994	82,408					82,408	23
24		ELECTRICAL IMPROVEMENTS		1993	96,457					96,457	24
25		WINDOWS		1990	3,975					3,975	25
26		LANDSCAPING		1989	3,960					3,960	26
27		CARPETING		1988	9,358					9,358	27
28		AIR CONDITIONING		1979	31,680					31,680	28
29		WINDOWS		1978	2,483					2,483	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**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								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		2,945,261	115,068		115,068		1,738,059	

\*\*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	\$ 25,808	\$ 2,581	\$ 2,581	\$		\$ 13,715	71
72	Current Year Purchases	17,340	867	867			867	72
73	Fully Depreciated Assets	546,025					546,025	73
74								74
75	TOTALS	\$ 589,173	\$ 3,448	\$ 3,448	\$		\$ 560,607	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	TRANSPORTATION	VAR.-SEE SCHEDULE	94-2007	\$ 238,365	\$ 7,760	\$ 7,760	\$		\$ 219,644	76
77										77
78										78
79										79
80	TOTALS			\$ 238,365	\$ 7,760	\$ 7,760	\$		\$ 219,644	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,175,799	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,276	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,276	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)	\$ 2,518,310	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2006

Ending: 06-30-2007

**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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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 checked="" type="checkbox"/> YES <input 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 checked="" 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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" 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	200	600		800
3	Classroom Wages (a)	666	12,580		13,246
4	Clinical Wages (b)	1,332	25,160		26,492
5	In-House Trainer Wages (c)	1,980	31,020		33,000
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 4,178	\$ 69,360	\$	\$ 73,538
10	SUM OF line 9, col. 1 and 2 (e)	\$ 73,538			

**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	34
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>38</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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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>			\$		\$	\$		\$	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 RIVERSIDE FOUNDATION# 0022988Report Period Beginning: 07-01-2006

Ending:

06-30-2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06-30-2007

(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	\$ 306,735	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,143,644		3
4	Supply Inventory (priced at <u>cost</u> )	2,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			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>	\$ 1,452,379	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,757,171		12
13	Land	403,000		13
14	Buildings, at Historical Cost	2,945,261		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	827,538		16
17	Accumulated Depreciation (book methods)	(2,518,309)		17
18	Deferred Charges	5,200		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): <u>SEC DEP&amp;PPD DEF. COMP</u>	253,200		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,673,061	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,125,440	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 317,872	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 317,872	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,144,375		40
41	Bonds Payable			41
42	Deferred Compensation	275,034		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>	\$ 1,419,409	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,737,281	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,388,159	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,125,440	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,300,774</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,300,774</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>87,385</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>87,385</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,388,159</b>	<b>24</b> *

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

Facility Name & ID Number RIVERSIDE FOUNDATION# 0022988Report Period Beginning: 07-01-2006Ending: 06-30-2007**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	\$ 3,725,752	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,725,752	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	689,918	10
11	CNA Training Reimbursements	53,236	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 743,154	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	460,627	24
25	Interest and Other Investment Income***	203,795	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 664,422	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,133,328	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,169,919	31
32	Health Care	2,188,828	32
33	General Administration	1,281,646	33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	259,302	36
<b>D. Other Expenses (specify):</b>			
37			37
38	<b>NET LOSS RIVERSIDE DEVELOPMENTAL</b>	146,248	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,045,943	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	87,385	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 87,385	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2006

Ending:

06-30-2007

**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	2,080	2,080	\$ 30,000	\$ 14.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,688	7,755	152,202	19.63	3
4	Licensed Practical Nurses	14,224	15,022	279,804	18.63	4
5	CNAs & Orderlies	14,776	15,025	143,002	9.52	5
6	CNA Trainees	6,094	6,499	59,115	9.10	6
7	Licensed Therapist	1,765	1,885	35,818	19.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,885	4,002	26,850	6.71	9
10	Activity Assistants	138	138	1,040	7.54	10
11	Social Service Workers	2,602	2,715	22,999	8.47	11
12	Dietician	1,295	1,295	16,200	12.51	12
13	Food Service Supervisor	1,755	1,802	29,000	16.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,022	31,885	304,812	9.56	15
16	Dishwashers					16
17	Maintenance Workers	5,077	5,255	77,190	14.69	17
18	Housekeepers	11,228	11,885	121,680	10.24	18
19	Laundry	4,816	5,022	41,592	8.28	19
20	Administrator	2,080	2,080	121,253	58.29	20
21	Assistant Administrator	2,080	2,080	119,120	57.27	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	31,000	14.90	23
24	Clerical	10,885	11,024	91,113	8.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	21,852	22,419	268,902	11.99	28
29	Resident Services Coordinator	3,188	3,366	59,885	17.79	29
30	Habilitation Aides (DD Homes)	82,966	84,072	823,745	9.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,576	239,386	\$ 2,856,322 *	\$ 11.93	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	250	\$ 9,750	LN10,COL3	35
36	Medical Director	2,080	30,000	LN10,COL3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	80	4,800	LN10,COL3	39
40	Physical Therapy Consultant	185	10,063	LN10,COL3	40
41	Occupational Therapy Consultant	787	44,792	LN10, COL3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	854	47,773	LN10,COL3	43
44	Activity Consultant				44
45	Social Service Consultant	95	1,890	LN10,COL3	45
46	Other(specify) <u>PSYCHOLOGIST</u>	266	19,920	LN10,COL3	46
47	<u>PSYCHIATRIST</u>	20	6,000	LN10,COL3	47
48	<u>OPTNOMOLOGIST</u>	7,500	1,920	LN10,COL3	48
49	TOTAL (lines 35 - 48)	12,117	\$ 176,908		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	635	\$ 30,491	LN10,COL1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	635	\$ 30,491		53

Facility Name & ID Number RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2006

Ending: 06-30-2007

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
PETER MULE'	DIRECTOR		\$ 121,253	Workers' Compensation Insurance	\$ 85,886	IDPH License Fee	\$		
PATRICIA WEISER	ADMINISTRATOR		119,120	Unemployment Compensation Insurance	31,077	Advertising: Employee Recruitment	9,293		
				FICA Taxes	212,999	Health Care Worker Background Check	564		
				Employee Health Insurance	208,807	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*					
				Deferred Comp>	59,546				
				Misc.Expense	6,788				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 240,373						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
PUBLIC RELATIONS			\$ 650	NONE			Out-of-State Travel	\$	
CONTRACTED SERVICE			2,764				In-State Travel		
							Seminar Expense	11,414	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 3,414	TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,857
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		\$ 11,414
C. Professional Services									
Vendor/Payee	Type		Amount						
HAROLD D BLACKBURN INC	ACCTG SERV		\$ 18,350						
HENRY&DONELSON ENT INC.	TAX SERV		21,395						
ADVANTAGE PAYROLL	PAYROLL SERV.		7,206						
RICHARDS,RALPH&SCHWAB	LEGAL SERV.		13,063						
SHEFSKY & FROELICH	LEGAL SERV.		4,498						
IL. HEALTH CARE	PROF DUES		5,352						
ITEMS LESS THAN \$2500			10,246						
TOTAL (agree to Schedule V, line 19, column 3)									
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,110						

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number RIVERSIDE FOUNDATION

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL. HEALTH CARE ASSN.
- (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? N/A
- (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? NA
- (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? 10YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 259,302  
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. \$ NO Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100
- 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? N/A
- g. Does the facility transport residents to and from day training? YES**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 44,579**
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: HAROLD D. BLACKBURN INC. 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.