



Facility Name & ID Number RIVERSHORES CARE CENTER

# 0049528 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	18,174		5,585	23,759	8
9	SNF/PED					9
10	ICF		5,588		5,588	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,174	5,588	5,585	29,347	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.06%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? 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 5/1/07

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 5/1/07 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 103 and days of care provided 5,453

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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	175,090	18,445	10,392	203,927		203,927		203,927		1
2	Food Purchase		168,880		168,880		168,880	(4,990)	163,890		2
3	Housekeeping	68,224	25,034		93,258		93,258		93,258		3
4	Laundry	76,973	7,860		84,833		84,833		84,833		4
5	Heat and Other Utilities			125,177	125,177		125,177	2,449	127,626		5
6	Maintenance	48,597		50,058	98,655		98,655	2,485	101,140		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	368,884	220,219	185,627	774,730		774,730	(56)	774,674		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,728	13,728		13,728		13,728		9
10	Nursing and Medical Records	1,514,771	135,582	5,971	1,656,324		1,656,324		1,656,324		10
10a	Therapy	12,518		580,495	593,013		593,013		593,013		10a
11	Activities	72,332	6,198	4,546	83,076		83,076		83,076		11
12	Social Services	52,447	1,240		53,687		53,687		53,687		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,652,068	143,020	604,740	2,399,828		2,399,828		2,399,828		16
	<b>C. General Administration</b>										
17	Administrative	70,460		98,880	169,340		169,340	33,145	202,485		17
18	Directors Fees										18
19	Professional Services			127,186	127,186		127,186	3,957	131,143		19
20	Dues, Fees, Subscriptions & Promotions			70,919	70,919		70,919	(46,827)	24,092		20
21	Clerical & General Office Expenses	128,765	37,550	45,962	212,277		212,277	39,755	252,032		21
22	Employee Benefits & Payroll Taxes			423,269	423,269		423,269		423,269		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,984	12,984		12,984	185	13,169		24
25	Other Admin. Staff Transportation			22,000	22,000		22,000	5,922	27,922		25
26	Insurance-Prop.Liab.Malpractice			85,041	85,041		85,041	431	85,472		26
27	Other (specify):*							12,089	12,089		27
28	<b>TOTAL General Administration</b>	199,225	37,550	886,241	1,123,016		1,123,016	48,657	1,171,673		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,220,177	400,789	1,676,608	4,297,574		4,297,574	48,601	4,346,175		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							81,835	81,835			30
31	Amortization of Pre-Op. & Org.							114	114			31
32	Interest			10,743	10,743		10,743	86,285	97,028			32
33	Real Estate Taxes			51,392	51,392		51,392	1,055	52,447			33
34	Rent-Facility & Grounds			323,317	323,317		323,317	(323,317)				34
35	Rent-Equipment & Vehicles			47,888	47,888		47,888	377	48,265			35
36	Other (specify):*							23,890	23,890			36
37	<b>TOTAL Ownership</b>			433,340	433,340		433,340	(129,761)	303,579			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			190,048	190,048		190,048		190,048			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,395	56,395		56,395		56,395			42
43	Other (specify):*							(35,759)	(35,759)			43
44	<b>TOTAL Special Cost Centers</b>			246,443	246,443		246,443	(35,759)	210,684			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,220,177	400,789	2,356,391	4,977,357		4,977,357	(116,919)	4,860,438			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,971)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,506)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,313)	21		18
19	Entertainment				19
20	Contributions	(4,189)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(45,732)	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	(39,093)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (98,823)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(18,096)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (18,096)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (116,919)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52	
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RIVERSHORES CARE CENTER

ID# 0049528

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	\$ (1,482)	20	1
2	TAXES - GENERAL	(629)	21	2
3	VENDING INCOME	(1,223)	21	3
4	MARKETING - SALARIES	(30,033)	43	4
5	MARKETING - EMPLOYEE BENEFITS	(5,726)	43	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>	(39,093)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVERSHORES CARE CENTER# 0049528

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,990)	0	0	0	0	0	0	0	0	0	0	(4,990)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,449	0	0	0	0	0	0	0	0	2,449	5
6	Maintenance	0	0	2,485	0	0	0	0	0	0	0	0	2,485	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,990)</b>	<b>0</b>	<b>4,934</b>	<b>0</b>	<b>(56)</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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	33,145	0	0	0	0	0	0	0	0	33,145	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,957	0	0	0	0	0	0	0	0	3,957	19
20	Fees, Subscriptions & Promotions	(47,214)	0	387	0	0	0	0	0	0	0	0	(46,827)	20
21	Clerical & General Office Expenses	(7,354)	0	47,109	0	0	0	0	0	0	0	0	39,755	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	185	0	0	0	0	0	0	0	0	185	24
25	Other Admin. Staff Transportation	0	0	5,922	0	0	0	0	0	0	0	0	5,922	25
26	Insurance-Prop.Liab.Malpractice	0	0	431	0	0	0	0	0	0	0	0	431	26
27	Other (specify):*	0	0	12,089	0	0	0	0	0	0	0	0	12,089	27
28	<b>TOTAL General Administration</b>	<b>(54,568)</b>	<b>0</b>	<b>103,225</b>	<b>0</b>	<b>48,657</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(59,558)</b>	<b>0</b>	<b>108,159</b>	<b>0</b>	<b>48,601</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVERSHORES CARE CENTER# 0049528

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	80,379	1,456	0	0	0	0	0	0	0	0	81,835	30
31	Amortization of Pre-Op. & Org.	0	0	114	0	0	0	0	0	0	0	0	114	31
32	Interest	(3,506)	88,184	1,607	0	0	0	0	0	0	0	0	86,285	32
33	Real Estate Taxes	0	0	1,055	0	0	0	0	0	0	0	0	1,055	33
34	Rent-Facility & Grounds	0	(323,317)	0	0	0	0	0	0	0	0	0	(323,317)	34
35	Rent-Equipment & Vehicles	0	0	377	0	0	0	0	0	0	0	0	377	35
36	Other (specify):*	0	23,890	0	0	0	0	0	0	0	0	0	23,890	36
37	<b>TOTAL Ownership</b>	<b>(3,506)</b>	<b>(130,864)</b>	<b>4,609</b>	<b>0</b>	<b>(129,761)</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	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(35,759)	0	0	0	0	0	0	0	0	0	0	(35,759)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(35,759)</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>(35,759)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(98,823)</b>	<b>(130,864)</b>	<b>112,768</b>	<b>0</b>	<b>(116,919)</b>	<b>45</b>							

Facility Name & ID Number

RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning:

1/1/09

Ending:

12/31/09

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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	34 RENTAL INCOME	\$ 323,317	PHRS REALTY, LLC		\$	(323,317)	1
2	V	30 DEPRECIATION				80,379	80,379	2
3	V	32 INTEREST				88,184	88,184	3
4	V	36 AMORTIZATION-LOAN COSTS				23,890	23,890	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		\$ 323,317			\$ 192,453	\$ * (130,864)	14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Home Office	\$	Platinum Health Care, LLC	100.00%	\$		15
16	V	5 Utilities		Platinum Health Care, LLC		2,449	2,449	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		2,485	2,485	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		33,145	33,145	18
19	V	19 Professional Fees		Platinum Health Care, LLC		3,957	3,957	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		387	387	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		41,138	41,138	21
22	V	21 Office Expenses		Platinum Health Care, LLC		5,971	5,971	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		185	185	23
24	V	25 Travel		Platinum Health Care, LLC		5,922	5,922	24
25	V	26 Insurance		Platinum Health Care, LLC		431	431	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		12,089	12,089	26
27	V	30 Depreciation		Platinum Health Care, LLC		565	565	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		377	377	28
29	V	31 Amortization		Platinum Health Care, LLC		114	114	29
30	V	30 Depreciation		Platinum Health Care, LLC		891	891	30
31	V	32 Interest		Platinum Health Care, LLC		1,607	1,607	31
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		1,055	1,055	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$ 112,768	\$ * 112,768	39

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

Facility Name & ID Number **RIVERSHORES CARE CENTER** # **0049528** Report Period Beginning: **1/1/09** Ending: **12/31/09**

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	BEN KLEIN		Administrative	1.00	SEE ATTACHED	2	6.90	Mgt Fees	\$	1
2	BRIAN LEVINSON		Administrative	27.50	SEE ATTACHED	4	10.00	Mgt Fees		2
3	MARK SHAPIRO		Administrative	10.00	SEE ATTACHED	6	15.00	Mgt Fees		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Platinum Health Care, LLC  
 Street Address 7444 Long Avenue  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847 ) 329-4100  
 Fax Number ( 847 ) 329-7652

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	606,157	15	\$ 50,576	\$ 29,347	\$ 2,449	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	29,347	2,485	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	33,145	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	29,347	3,957	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	29,347	387	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	41,138	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	29,347	5,971	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	29,347	185	8
9	25	Travel	Patient Days	606,157	15	122,325	29,347	5,922	9
10	26	Insurance	Patient Days	606,157	15	8,909	29,347	431	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	29,347	12,089	11
12	30	Depreciation	Patient Days	606,157	15	11,677	29,347	565	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	29,347	377	13
14	31	Amortization	Patient Days	606,157	15	2,355	29,347	114	14
15	30	Depreciation	Patient Days	606,157	15	18,405	29,347	891	15
16	32	Interest	Patient Days	606,157	15	33,183	29,347	1,607	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	29,347	1,055	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 112,768	25

Facility Name & ID Number

RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning:

1/1/09

Ending:

12/31/09

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										
										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	LASALLE BANK		X	Mortgage			\$	\$		\$ 88,184	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	LASALLE BANK		X	Line of Credit						10,743	6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 98,927	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income-offset									(3,506)	10								
11											11								
12											12								
13	Allocation from Platinum									1,607	13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (1,899)	14								
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 97,028	15								

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





Facility Name & ID Number RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning:

1/1/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,830 B. General Construction Type: Exterior BRICK Frame MASONARY Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning:

1/1/09

Ending:

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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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			2007		\$ 1,215,400	\$ 44,196	27.5	\$ 44,196	\$	\$ 95,759	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIGNS	2007		6,326		10	633	633	1,371	9
10		CONCRETE SLAB, SIDEWALK	2007		2,840		15	189	189	379	10
11		RENOVATE SHOWER ROOM-A.M REMODELING-CONTRACT	2008		4,500		27.5	164	164	314	11
12		MAT/LAB-INSTALL LAUNDRY ROOM BOILER-AL'S PLUMBING &	2008		4,883		20	244	244	488	12
13		INSTALL WATER HEATER-AL'S PLUMBING & HEATING	2008		5,228		10	523	523	1,002	13
14		HOYER POWER LIFTER	2008		3,464		10	346	346	693	14
15		PLASTER NORTH & EAST WALL-VILLAS CONCRETE	2008		10,000		27.5	364	364	667	15
16		NEW HOLDING TANK FOR BOILER	2008		3,000		20	150	150	263	16
17		REBUILD DISHWASHER-HOBART SERVICE	2008		1,834		10	183	183	321	17
18		INSTALL COMPRESSOR FOR KITCHEN A/C-MUCCI & KIRPATRICK	2008		1,932		10	193	193	290	18
19		CLEANED & SANITIZED ICE MACHINE--MUCCI & KIRKPATRICK	2008		499		10	50	50	75	19
20		REPLACE CONCRETE--S&E CONCRETE	2008		1,689		15	113	113	159	20
21		WATER HEATER	2009		5,500		10	550	550	550	21
22		MEDICAL ROOM DOOR & FRAME	2009		1,750		15	117	117	117	22
23		GENERATOR	2009		8,085		5	1,617	1,617	1,617	23
24		ELECTRICAL WORK	2009		16,169		20	674	674	674	24
25		DRYWALL WORK	2009		825		5	151	151	151	25
26		PAINT & REPAIR WALLS	2009		2,416		5	443	443	443	26
27		FIRE DAMPER	2009		1,193		20	45	45	45	27
28		NEW DOOR & FRAME	2009		1,850		15	92	92	92	28
29		RESURFACE PARKING LOT	2009		42,000		8	3,062	3,062	3,062	29
30		CONCRETE WORK	2009		3,500		15	156	156	156	30
31		CONCRETE WORK	2009		966		15	27	27	27	31
32		KITCHEN DUCT WORK	2009		1,433		20	24	24	24	32
33		CONCRETE WORK	2009		945		15	21	21	21	33
34						29,584			(29,584)		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 **RIVERSHORES CARE CENTER**

# **0049528**

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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					584	584		68
69								69
70		\$ 1,348,227	\$ 74,364		\$ 54,911	\$ (19,453)	\$ 108,760	70

\*\*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	\$ 190,216	\$ 44,796	\$ 24,102	\$ (20,694)		\$ 51,886	71
72	Current Year Purchases	40,350	24,210	1,950	(22,260)		1,950	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		872	872				74
75	<b>TOTALS</b>	\$ 230,566	\$ 69,878	\$ 26,924	\$ (42,954)		\$ 53,836	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,578,793	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 144,242	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,835	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (62,407)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 162,596	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 46,720 Description: ACP \$2,013; Medical \$31,514; Printer/copier \$6,633; Postage \$948; wound \$5,612

(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		<u>2009 Toyota Rav4</u>	\$ _____	\$ <u>1,168</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>1,168</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2010 \$ \_\_\_\_\_

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	10a-03	hrs	\$		\$ 282,557	\$		\$ 282,557	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			23,818			23,818	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			272,377			272,377	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				184,681		184,681	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	39-02					5,367		5,367	12
13	Other (specify): <u>Resp Therapist</u>	10a-03				1,743			1,743	13
14	<b>TOTAL</b>			\$		\$ 580,495	\$ 190,048		\$ 770,543	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 **RIVERSHORES CARE CENTER**

# **0049528**

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/09** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (30,944)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,010,373		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,323		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(1,715)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,043,037	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	90,373		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 90,373	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,133,410	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 404,389	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,527		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accrued Expenses	21,236		36
37	Due Others, Adv. Billing	170,370		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 675,022	\$	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>	\$ 675,022	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 458,388	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,133,410	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>144,015</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</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>144,014</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>314,374</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>314,374</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>458,388</b>	<b>24</b> *

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,730,384	1
2	Discounts and Allowances for all Levels	(309,555)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,420,829	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,660,755	6
7	Oxygen	16,235	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,676,990	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		12
13	Barber and Beauty Care	(23)	13
14	Non-Patient Meals	4,971	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,589	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,178	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 189,183	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,506	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,506	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending Income</u>	1,223	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,223	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,291,731	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	774,730	31
32	Health Care	2,399,828	32
33	General Administration	1,123,016	33
<b>B. Capital Expense</b>			
34	Ownership	433,340	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	190,048	35
36	Provider Participation Fee	56,395	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,977,357	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	314,374	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 314,374	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. Tax Return filed on Cash Basis

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

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

Facility Name & ID Number **RIVERSHORES CARE CENTER**

# **0049528**

Report Period Beginning:

**1/1/09**

Ending:

**12/31/09**

**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	2,318	2,463	\$ 71,044	\$ 28.84	1
2	Assistant Director of Nursing	1,696	1,809	42,839	23.68	2
3	Registered Nurses	16,027	16,513	360,766	21.85	3
4	Licensed Practical Nurses	16,302	17,149	359,928	20.99	4
5	CNAs & Orderlies	66,927	68,400	640,418	9.36	5
6	CNA Trainees					6
7	Licensed Therapist	19	43	1,396	32.47	7
8	Rehab/Therapy Aides	1,099	1,110	11,122	10.02	8
9	Activity Director	1,961	2,083	35,586	17.08	9
10	Activity Assistants	4,222	4,274	36,746	8.60	10
11	Social Service Workers	3,524	3,714	52,447	14.12	11
12	Dietician					12
13	Food Service Supervisor	1,867	2,188	28,897	13.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,387	15,156	146,193	9.65	15
16	Dishwashers					16
17	Maintenance Workers	2,747	2,989	48,597	16.26	17
18	Housekeepers	7,603	7,782	68,224	8.77	18
19	Laundry	9,014	9,320	76,973	8.26	19
20	Administrator	1,904	2,121	70,460	33.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,082	7,938	128,765	16.22	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	1,823	2,082	39,776	19.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,522	167,134	\$ 2,220,177 *	\$ 13.28	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	198	\$ 9,292	1-03	35
36	Medical Director	Monthly	13,728	9-03	36
37	Medical Records Consultant	Monthly	1,840	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,131	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,206	11-03	44
45	Social Service Consultant	20	1,240	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 32,437		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

**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	
<b>Odelia Underwood</b>	<b>Administrator</b>		\$ <b>70,460</b>	<b>Workers' Compensation Insurance</b>	\$ <b>90,866</b>	<b>IDPH License Fee</b>	\$	
				<b>Unemployment Compensation Insurance</b>	<b>46,708</b>	<b>Advertising: Employee Recruitment</b>	<b>12,916</b>	
				<b>FICA Taxes</b>	<b>165,341</b>	<b>Health Care Worker Background Check</b>	<b>1,000</b>	
				<b>Employee Health Insurance</b>	<b>107,379</b>	(Indicate # of checks performed <b>88</b> )		
				<b>Employee Meals</b>		<b>Patient Background Checks</b>	<b>131</b>	
				<b>Illinois Municipal Retirement Fund (IMRF)*</b>		<b>ADVERTISING &amp; MARKETING</b>	<b>45,732</b>	
				<b>401K</b>	<b>100</b>	<b>DUES &amp; SUBSCRIPTIONS</b>	<b>8,804</b>	
				<b>EMPLOYEE BENEFITS-OTHER</b>	<b>11,553</b>	<b>LICENSES</b>	<b>985</b>	
				<b>EMPLOYEE PHYSICAL EXAM</b>	<b>1,322</b>			
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <b>70,460</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		\$ <b>423,269</b>		
<b>(List each licensed administrator separately.)</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
<b>B. Administrative - Other</b>						\$ <b>24,092</b>		
<b>Description</b>			<b>Amount</b>					
			\$					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$					
<b>(Attach a copy of any management service agreement)</b>								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<b>SEE ATTACHED SCHEDULE</b>			\$ <b>127,186</b>			\$	<b>Out-of-State Travel</b>	\$
							<b>In-State Travel</b>	
							<b>Seminar Expense</b>	<b>12,984</b>
							<b>ALLOCATION FROM PLATINUM</b>	<b>185</b>
							<b>Entertainment Expense</b>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <b>127,186</b>	<b>TOTAL</b>		\$	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							\$ <b>13,169</b>	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number RIVERSHORES CARE CENTER

# 0049528

Report Period Beginning: 1/1/09

Ending: 12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$7,365
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,243 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,395  
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.