



Facility Name & ID Number RIVERSIDE FOUNDATION

# 0022988 Report Period Beginning: 07-01-2008 Ending: 06-30-2009

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 97

	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>35405</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>35405</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>35,243</u>	<u>0</u>	<u>0</u>	<u>35,243</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,243</u>			<u>35,243</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.54%

D. How many bed-hold days during this year were paid by the Department? 2,208 (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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

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

IV. ACCOUNTING BASIS

ACCRUAL  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: 07-01-2008 Ending: 06-30-2009

**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	368,970	33,160	8,675	410,805		410,805		410,805		1
2	Food Purchase		250,169		250,169		250,169	(36,775)	213,394		2
3	Housekeeping	125,610	35,472		161,082		161,082		161,082		3
4	Laundry	49,705	2,243	57,715	109,663		109,663		109,663		4
5	Heat and Other Utilities			120,691	120,691		120,691		120,691		5
6	Maintenance	64,925	23,843	52,701	141,469		141,469		141,469		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	609,210	344,887	239,782	1,193,879		1,193,879	(36,775)	1,157,104		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	757,410	30,671	67,564	855,645		855,645		855,645		10
10a	Therapy										10a
11	Activities	1,140,087	19,622	98,711	1,258,420		1,258,420		1,258,420		11
12	Social Services	59,607		7,184	66,791		66,791		66,791		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,957,104	50,293	173,459	2,180,856		2,180,856		2,180,856		16
	<b>C. General Administration</b>										
17	Administrative	213,188		2,907	216,095		216,095		216,095		17
18	Directors Fees										18
19	Professional Services			87,313	87,313		87,313		87,313		19
20	Dues, Fees, Subscriptions & Promotions			4,512	4,512		4,512		4,512		20
21	Clerical & General Office Expenses	100,103	21,394		121,497		121,497		121,497		21
22	Employee Benefits & Payroll Taxes			480,539	480,539		480,539		480,539		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,761	8,761		8,761		8,761		24
25	Other Admin. Staff Transportation			21,911	21,911		21,911		21,911		25
26	Insurance-Prop.Liab.Malpractice			34,515	34,515		34,515		34,515		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	313,291	21,394	640,458	975,143		975,143		975,143		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,879,605	416,574	1,053,699	4,349,878		4,349,878	(36,775)	4,313,103		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			103,668	103,668		103,668		103,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,417	47,417		47,417		47,417			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>			151,085	151,085		151,085		151,085			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			245,784	245,784		245,784		245,784			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			245,784	245,784		245,784		245,784			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,879,605	416,574	1,450,568	4,746,747		4,746,747	(36,775)	4,709,972			45

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



RIVERSIDE FOUNDATION

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	NOT APPLICABLE	\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			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





**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		\$	NOT APPLICABLE		\$	\$	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	<b>Total</b>		\$			\$	\$ *	14

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

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	<b>NOT APPLICABLE</b>								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								<b>TOTAL</b>	\$	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

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

Facility Name & ID Number

RIVERSIDE FOUNDATION

# 0022988

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06-30-2009

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	BAXTER CREDIT UNION	X	REAL ESTATE MORTGAGE	\$5,372.00	09-08-2008	\$ 750,000	\$ 734,831	10-01-2013	0.0595	\$ 47,417	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>			\$5,372.00		\$ 750,000	\$ 734,831			\$ 47,417	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>					\$ 750,000	\$ 734,831			\$ 47,417	15								

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



Facility Name & ID Number RIVERSIDE FOUNDATION

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**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>CARE RELATED</u>	<u>135,000</u>	<u>1990</u>	<u>\$ 403,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>135,000</b>		<b>\$ 403,000</b>	<b>3</b>

**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		\$ 982,635	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		FLOORING, FURNITURE, & OFFICE EQUIPMENT		2009	45,584	2,279	10	2,279		2,279	9
10		FURNITURE,EQUIPMENT,CABINETRY,&CONCRETE WORK		2008	83,640	8,364	10	8,364		15,189	10
11		OFFICE EQUIPMENT,& EXTERIOR IMPROVEMENTS		2007	46,716	4,672	10	4,672		11,680	11
12		ELECTRICAL IMPROVEMENTS&ENGINEERING COSTS		2006	45,858	4,586	10	4,586		16,051	12
13		ROOF IMP.,A/CIMP.,&ELECTRICAL WORK		2005	124,119	12,412	10	12,412		62,060	13
14		NEW ROADS,FENCES,LANDSCAPING & LIGHTING		2004	51,719	5,171	10	5,171		31,026	14
15		ENGINEERING FEES FOR ROADS &LANDSCAPING		2003	147,562	14,576	10	14,576		87,736	15
16		ARCHITECT FEES		2002	27,476	2,748	10	2,748		19,236	16
17		LAND ACQUISITION		2001	151,962						17
18		ELECTRICAL GENERATOR		2001	47,130	4,713	10	4,713		42,417	18
19		ELECTRICAL GENERATOR		2000	43,640	4,464	10	4,464		43,640	19
20		EXHAUST SYSTEM		1999	18,174					18,174	20
21		SUMP PUMP		1998	89,360					89,360	21
22		TV ANTENNA		1997	145,733					145,733	22
23		SHOWER ROOM		1996	57,631					57,631	23
24		PARKING LOT		1995	115,582					115,582	24
25		ELEVATOR		1994	82,408					82,408	25
26		ELECTRICAL UPGRADES		1993	96,457					96,457	26
27		WINDOWS		1990	3,975					3,975	27
28		LANDSCAPING		1989	3,960					3,960	28
29		CARPETING		1988	9,358					9,358	29
30		AIR CONDITIONING		1979	31,680					31,680	30
31		WINDOWS		1978	2,483					2,483	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	TOTAL (lines 4 thru 69)	\$ 3,074,485	\$ 117,394		\$ 117,394	\$	\$ 1,970,750	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	\$ 72,396	\$ 4,314	\$ 4,314	\$		\$ 24,672	71
72	Current Year Purchases	28,833	1,441	1,441			1,441	72
73	Fully Depreciated Assets	546,025					546,025	73
74								74
75	<b>TOTALS</b>	\$ 647,254	\$ 5,755	\$ 5,755	\$		\$ 572,138	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	1994-2007	\$ 233,818	\$ 5,683	\$ 5,683	\$		\$ 233,086	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 233,818	\$ 5,683	\$ 5,683	\$		\$ 233,086	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)	\$ 4,358,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 128,832	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,832	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)	\$ 2,775,974	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: \$ \_\_\_\_\_ 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

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 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><b>2. CLASSROOM PORTION:</b></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      <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER CNA      <u>80</u></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	53	743		796
3	Classroom Wages (a)	171	5,320		5,491
4	Clinical Wages (b)	342	10,640		10,982
5	In-House Trainer Wages (c)	2,701	37,817		40,518
6	Transportation				
7	Contractual Payments	119	1,662		1,781
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$ 3,386	\$ 56,182	\$	\$ 59,568
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 59,568			

**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	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>15</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		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	Other (specify): _____									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**# **0022988**Report Period Beginning: **07-01-2008**Ending: **06-30-2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06-30-2009**

(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	\$ 1,120,143	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,396,750		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>	\$ 2,518,893	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	403,000		13
14	Buildings, at Historical Cost	3,074,485		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	881,072		16
17	Accumulated Depreciation (book methods)	(2,775,974)		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): <u>SEC.DEP/DEF.COMP/PPD.EXP</u>	219,568		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,802,151	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,321,044	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 282,141	\$	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>	\$ 282,141	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	734,831		40
41	Bonds Payable			41
42	Deferred Compensation	147,135		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>	\$ 881,966	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,164,107	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,156,937	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,321,044	\$	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>3,268,659</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>3,268,659</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(111,722)	<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>	\$ (111,722)	<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>3,156,937</b>	<b>24</b> *

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

Facility Name & ID Number **RIVERSIDE FOUNDATION**

# 0022988

Report Period Beginning: 07-01-2008

Ending: 06-30-2009

**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	\$ 3,804,015	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,804,015	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	716,494	10
11	CNA Training Reimbursements	14,122	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>	\$ 730,616	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	305,973	24
25	Interest and Other Investment Income***	(3,878)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 302,095	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>	\$ 4,836,726	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,292,020	31
32	Health Care	2,144,383	32
33	General Administration	1,064,560	33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	245,784	36
<b>D. Other Expenses (specify):</b>			
37	<b>NET LOSS RIVERSIDE DEVELOPMENTAL</b>	201,701	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,948,448	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(111,722)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (111,722)	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**

# ###

Report Period Beginning: 7/1/2008

Ending:

6/30/2009

**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	\$ 75,273	\$ 36.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,296	12,296	358,296	29.14	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	17,264	17,264	208,899	12.10	5
6	CNA Trainees	6,944	7,765	74,044	9.54	6
7	Licensed Therapist	1,150	1,205	23,795	19.75	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	29,803	14.33	9
10	Activity Assistants					10
11	Social Service Workers	3,016	3,255	29,803	9.16	11
12	Dietician	1,303	1,303	17,103	13.13	12
13	Food Service Supervisor	2,080	2,080	54,080	26.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,743	27,743	314,890	11.35	15
16	Dishwashers					16
17	Maintenance Workers	3,968	4,188	64,925	15.50	17
18	Housekeepers	11,165	11,165	125,610	11.25	18
19	Laundry	2,841	2,841	49,705	17.50	19
20	Administrator	2,080	2,080	126,938	61.03	20
21	Assistant Administrator	2,080	2,080	86,250	41.47	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	42,036	20.21	23
24	Clerical	3,600	3,600	58,067	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	22,335	22,335	323,861	14.50	28
29	Resident Services Coordinator	2,080	2,080	74,256	35.70	29
30	Habilitation Aides (DD Homes)	64,711	65,953	741,971	11.25	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,896	195,473	\$ 2,879,605 *	\$ 14.73	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	24	\$ 1,058	LN.10COL.3	35
36	Medical Director	260	30,000	LN.9COL.1	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	80	4,800	LN.11COL.3	39
40	Physical Therapy Consultant	193	11,546	LN.11COL.3	40
41	Occupational Therapy Consultant	481	30,079	LN.10COL.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	683	42,048	LN.11COL.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Program Consultant</u>	287	5,634	LN.11COL.3	46
47	<u>Psychologist&amp;Psychiatrist</u>	246	24,870	LN.11COL.3	47
48	<u>Ophthalmologist Consultant</u>		2,208	LN.11COL.3	48
49	TOTAL (lines 35 - 48)	2,254	\$ 152,243		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	185	\$ 10,596	LN.10COL.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	185	\$ 10,596		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
PETER MULE'	DIRECTOR		\$ 126,938	Workers' Compensation Insurance	\$ 100,787	IDPH License Fee	\$		
DEBORAH ROGERS	ADMINISTRATOR		86,250	Unemployment Compensation Insurance	14,546	Advertising: Employee Recruitment		3,600	
				FICA Taxes	220,289	Health Care Worker Background Check		912	
				Employee Health Insurance	148,267	(Indicate # of checks performed <u>60</u> )			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
				Miscellaneous expense	4,615				
				Deferred compensation	(7,965)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 213,188						
B. Administrative - Other									
Description			Amount						
CONTRACTED SERVICE			\$ 2,907			Less: Public Relations Expense	(	)	
						Non-allowable advertising	(	)	
						Yellow page advertising	(	)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 2,907	TOTAL (agree to Schedule V, line 22, col.8)	\$ 480,539	TOTAL (agree to Sch. V, line 20, col. 8)	\$	4,512	
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	
HAROLD D. BLACKBURN INC.	ACCTG. SERVICES		\$ 30,950			\$	Out-of-State Travel	\$	
HENRY&DONELSON ENT INC	TAX PREP. SERVICES		8,385						
MASUDA,FUNALEIFERT	LEGAL SERVICES		5,640				In-State Travel		
SHEFSKY &FROELICH	LEGAL SERVICES		26,675						
IL HEALTH CARE ASSN.	PROF. DUES		1,784						
ADVANTAGE PAYROLL SERV.	PAYROLL SERVICES		7,141						
RICHARDS & RALPH	LEGAL SERVICES		4,724				Seminar Expense	8,761	
ITEMS<\$2500			2,014						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 87,313	TOTAL		\$	Entertainment Expense	(	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number RIVERSIDE FOUNDATION

# 0022988

Report Period Beginning: 07-01-2008 Ending: 06-30-2009

## 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 \$1784
- (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? 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. \$ 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. \$ 245,784  
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? YES
- 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.** \$ 62,198
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: HAROLD D. BLACKBURN INC.
- (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.