FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049528

Facility Name: RIVERSHORES CARE CENTER

Address: 578 WEST COMMERCIAL STREET (Number) MARSEILLES (City) 61341 (Zip Code)

County: LASALLE

Telephone Number: (815) 795-5121 **Fax #** (815) 795-4929

HFS ID Number:

Date of Initial License for Current Owners: 5/1/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,102		4,259	21,361	8
9	SNF/PED					9
10	ICF		4,499		4,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,102	4,499	4,259	25,860	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.79%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 5/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 3,888

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	177,034	14,308	8,733	200,075		200,075		200,075			1
2	Food Purchase		154,902		154,902		154,902	(5,148)	149,754			2
3	Housekeeping	86,358	15,992		102,350		102,350		102,350			3
4	Laundry	53,784	11,744		65,528		65,528		65,528			4
5	Heat and Other Utilities			114,736	114,736		114,736	2,317	117,053			5
6	Maintenance	45,786		48,741	94,527		94,527	2,173	96,700			6
7	Other (specify):*											7
8	TOTAL General Services	362,962	196,946	172,210	732,118		732,118	(658)	731,460			8
	B. Health Care and Programs											
9	Medical Director			13,728	13,728		13,728		13,728			9
10	Nursing and Medical Records	1,446,319	100,546	5,599	1,552,464		1,552,464		1,552,464			10
10a	Therapy	36,787		471,600	508,387		508,387		508,387			10a
11	Activities	73,841	8,028	7,303	89,172		89,172		89,172			11
12	Social Services	53,010		2,097	55,107		55,107		55,107			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,609,957	108,574	500,327	2,218,858		2,218,858		2,218,858			16
	C. General Administration											
17	Administrative	74,904		98,880	173,784		173,784	(90,033)	83,751			17
18	Directors Fees											18
19	Professional Services			163,014	163,014		163,014	(467)	162,547			19
20	Dues, Fees, Subscriptions & Promotions			48,474	48,474		48,474	(31,934)	16,540			20
21	Clerical & General Office Expenses	142,027	39,013	40,555	221,595		221,595	(26,821)	194,774			21
22	Employee Benefits & Payroll Taxes			360,100	360,100		360,100	(12,103)	347,997			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,141	13,141		13,141	205	13,346			24
25	Other Admin. Staff Transportation			24,984	24,984		24,984	2,928	27,912			25
26	Insurance-Prop.Liab.Malpractice			78,552	78,552		78,552	299	78,851			26
27	Other (specify):*							6,564	6,564			27
28	TOTAL General Administration	216,931	39,013	827,700	1,083,644		1,083,644	(151,362)	932,282			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,189,850	344,533	1,500,237	4,034,620		4,034,620	(152,020)	3,882,600			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RIVERSHORES CARE CENTER #0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,888	12,888		12,888	71,052	83,940			30
31	Amortization of Pre-Op. & Org.							163	163			31
32	Interest			4,825	4,825		4,825	117,478	122,303			32
33	Real Estate Taxes			48,118	48,118		48,118	778	48,896			33
34	Rent-Facility & Grounds			323,317	323,317		323,317	(323,317)				34
35	Rent-Equipment & Vehicles			29,043	29,043		29,043	121	29,164			35
36	Other (specify):*							31,260	31,260			36
37	**TOTAL Ownership**			418,191	418,191		418,191	(102,465)	315,726			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			142,388	142,388		142,388		142,388			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			198,781	198,781		198,781		198,781			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,189,850	344,533	2,117,209	4,651,592		4,651,592	(254,485)	4,397,107			45

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,133)	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	(125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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				18
19	Entertainment				19
20	Contributions	(2,500)	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	(28,830)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(105,503)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (142,106)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(112,379)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (112,379)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (254,485)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

RIVERSHORES CARE CENTER

ID# 0049528

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (3,771)	20	1
2	VENDING INCOME	(2,246)	21	2
3	MISC INCOME	(5)	21	3
4	MARKETING SALARIES	(73,604)	21	4
5	MARKETING EMPLOYEE BENEFITS	(12,103)	22	5
6	ADJUST SL DEPR	(13,470)	30	6
7	TAXES - GENERAL	(304)	21	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	**Total**	(105,503)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,148)	0	0	0	0	0	0	0	0	0	0	(5,148)	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	2,317	0	0	0	0	0	0	0	0	2,317	5
6	Maintenance	0	0	2,173	0	0	0	0	0	0	0	0	2,173	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,148)	0	4,490	0	0	0	0	0	0	0	0	(658)	8
	B. Health Care and Programs													
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	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(90,033)	0	0	0	0	0	0	0	0	(90,033)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,061)	3,594	0	0	0	0	0	0	0	0	(467)	19
20	Fees, Subscriptions & Promotions	(32,601)	0	667	0	0	0	0	0	0	0	0	(31,934)	20
21	Clerical & General Office Expenses	(78,659)	0	51,838	0	0	0	0	0	0	0	0	(26,821)	21
22	Employee Benefits & Payroll Taxes	(12,103)	0	0	0	0	0	0	0	0	0	0	(12,103)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	205	0	0	0	0	0	0	0	0	205	24
25	Other Admin. Staff Transportation	0	0	2,928	0	0	0	0	0	0	0	0	2,928	25
26	Insurance-Prop.Liab.Malpractice	0	0	299	0	0	0	0	0	0	0	0	299	26
27	Other (specify):*	0	0	6,564	0	0	0	0	0	0	0	0	6,564	27
28	**TOTAL General Administration**	(123,363)	(4,061)	(23,938)	0	0	0	0	0	0	0	0	(151,362)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,511)	(4,061)	(19,448)	0	0	0	0	0	0	0	0	(152,020)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,470)	83,080	1,442	0	0	0	0	0	0	0	0	71,052	30
31	Amortization of Pre-Op. & Org.	0	0	163	0	0	0	0	0	0	0	0	163	31
32	Interest	(125)	116,218	1,385	0	0	0	0	0	0	0	0	117,478	32
33	Real Estate Taxes	0	0	778	0	0	0	0	0	0	0	0	778	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	121	0	0	0	0	0	0	0	0	121	35
36	Other (specify):*	0	31,260	0	0	0	0	0	0	0	0	0	31,260	36
37	**TOTAL Ownership**	(13,595)	(92,759)	3,889	0	0	0	0	0	0	0	0	(102,465)	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(142,106)	(96,820)	(15,559)	0	0	0	0	0	0	0	0	(254,485)	45

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 323,317	PHRS REALTY, LLC		$	$ (323,317)	1
2	V	30	DEPRECIATION				83,080	83,080	2
3	V	32	INTEREST				116,218	116,218	3
4	V	36	AMORTIZATION-LOAN COSTS				31,260	31,260	4
5	V								5
6	V								6
7	V	19	PROFESSIONAL FEES	74,400	PHC CONSULTANTS, LLC		70,339	(4,061)	7
8	V								8
9	V	19	PROFESSIONAL FEES	3,325	MTS CONSULTING		3,325		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 401,042			$ 304,222	$ * (96,820)	14

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 98,880	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (98,880)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC	100.00%	2,317	2,317	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC	100.00%	2,173	2,173	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC	100.00%	8,847	8,847	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC	100.00%	3,594	3,594	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC	100.00%	667	667	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC	100.00%	45,813	45,813	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC	100.00%	6,025	6,025	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC	100.00%	205	205	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC	100.00%	2,928	2,928	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC	100.00%	299	299	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC	100.00%	6,564	6,564	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC	100.00%	623	623	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC	100.00%	121	121	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC	100.00%	163	163	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC	100.00%	819	819	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC	100.00%	1,385	1,385	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC	100.00%	778	778	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,880			$ 83,321	$ * (15,559)	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: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	4.34	SEE ATTACHED	2	6.45	Mgt Fees	$		1
2	BRIAN LEVINSON		Administrative	30.83	SEE ATTACHED	6	15.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	13.33	SEE ATTACHED	4	10.00	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: 1/1/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	581,243	18	$ 52,068	$	25,860	$ 2,317	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		25,860	2,173	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	25,860	8,847	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		25,860	3,594	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		25,860	667	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	25,860	45,813	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		25,860	6,025	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		25,860	205	8
9	25	Travel	Patient Days	581,243	18	65,815		25,860	2,928	9
10	26	Insurance	Patient Days	581,243	18	6,717		25,860	299	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		25,860	6,564	11
12	30	Depreciation	Patient Days	581,243	18	14,004		25,860	623	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		25,860	121	13
14	31	Amortization	Patient Days	581,243	18	3,657		25,860	163	14
15	30	Depreciation	Patient Days	581,243	18	18,405		25,860	819	15
16	32	Interest	Patient Days	581,243	18	31,121		25,860	1,385	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		25,860	778	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 83,321	25

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK/THE PRIVATE BA		X	MORTGAGE			$	$			$ 116,218	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT							4,825	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 121,043	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(125)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,385	13
14	TOTAL Non-Facility Related						$	$			$ 1,260	14
15	TOTALS (line 9+line14)						$	$			$ 122,303	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:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,500	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.)		$ 45,618	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,882)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,000	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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,118	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	37,439	8
2006		9
2007	42,915	10
2008	45,392	11
2009	45,618	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVERSHORES CARE CENTER COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0049528

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-49-325-027	Long Term Care Property	$ 44,999.98	$ 44,999.98
2.	15-49-325-026	Long Term Care Property	$ 617.92	$ 617.92
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,617.90	$ 45,617.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] (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 [X] (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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2007		$ 1,215,400	$ 44,196	27.5	$ 44,196	$	$ 139,955	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			2007	6,326		10	633	633	2,004	9
10	CONCRETE SLAB, SIDEWALK			2007	2,840		15	189	189	568	10
11	RENOVATE SHOWER ROOM-A.M REMODELING-CONTRACT			2008	4,500		27.5	164	164	478	11
12	MAT/LAB-INSTALL LAUNDRY ROOM BOILER-AL'S PLUMBING &			2008	4,883		20	244	244	732	12
13	INSTALL WATER HEATER-AL'S PLUMBING & HEATING			2008	5,228		10	523	523	1,525	13
14	HOYER POWER LIFTER (MOVE TO EQUIP-2009 DESK AUDIT)			2008	3,464		10	346	346	1,039	14
15	PLASTER NORTH & EAST WALL-VILLAS CONCRETE			2008	10,000		27.5	364	364	1,031	15
16	NEW HOLDING TANK FOR BOILER			2008	3,000		20	150	150	413	16
17	REBUILD DISHWASHER-HOBART SERV (REMOVED CAP DESK AU			2008			10				17
18	INSTALL COMPRESSOR FOR KITCHEN A/C-MUCCI & KIRPATRIC			2008			10				18
19	CLEANED & SANITIZED ICE MACHINE--MUCCI & KIRKPATRICK			2008			10				19
20	REPLACE CONCRETE--S&E CONCRETE (REMOVED CAP DESK AU			2008			15				20
21	WATER HEATER			2009	5,500		10	550	550	1,100	21
22	MEDICAL ROOM DOOR & FRAME (REMOVED CAP DESK AUDIT 2			2009			15				22
23	GENERATOR			2009	8,085		5	1,617	1,617	3,234	23
24	ELECTRICAL WORK			2009	16,169		20	808	808	1,482	24
25	DRYWALL WORK (REMOVED CAP DESK AUDIT 2009)			2009			5				25
26	PAINT & REPAIR WALLS (REMOVED CAP DESK AUDIT 2009)			2009			5				26
27	FIRE DAMPER (REMOVED CAP DESK AUDIT 2009)			2009			20				27
28	NEW DOOR & FRAME (REMOVED CAP DESK AUDIT 2009)			2009			15				28
29	RESURFACE PARKING LOT			2009	42,000		8	5,250	5,250	8,312	29
30	CONCRETE WORK			2009	3,500		15	233	233	389	30
31	CONCRETE WORK (REMOVED CAP DESK AUDIT 2009)			2009			15				31
32	KITCHEN DUCT WORK (REMOVED CAP DESK AUD 2009			2009			20				32
33	CONCRETE WORK (REMOVED CAP DESK AUDIT 2009)			2009		12411	15		(12,411)		33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SHOWER ROOM REMODELING-CONTRACT-A.M. REMODE	2010	$ 6,150	$ 121	27.5	$ 130	$ 9	$ 130	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	Allocation from Platinum			622		622			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,337,045	$ 57,350		$ 56,019	$ (1,331)	$ 162,392	70

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 234,798	$ 26,473	$ 26,473	$		$ 81,002	71
72	Current Year Purchases	12,767	12,767	628	(12,139)		628	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		820	820				74
75	TOTALS	$ 247,565	$ 40,060	$ 27,921	$ (12,139)		$ 81,630	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	TOTALS			$	$	$	$		$	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)	$ 1,584,610	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,410	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,940	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,470)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 244,022	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	TOTAL				$ **			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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $29,043 Description: Medical $19,721; Printer/copier $7,089; Postage $948; Dishwasher $1,285
(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	TOTAL		$	$	21

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

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(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.

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$	3,537	$ 212,206	$	3,537	$ 212,206	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		648	38,900		648	38,900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		3,662	219,726		3,662	219,726	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				135,984		135,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-02					6,404		6,404	12
13	Other (specify): Resp Therapist	10a-03			10	768		10	768	13
14	TOTAL			$	7,857	$ 471,600	$ 142,388	7,857	$ 613,988	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.

STATE OF ILLINOIS

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 42,728	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	809,943		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,668		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due Mcr	42,652		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 976,991	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,150		15
16	Equipment, at Historical Cost	12,766		16
17	Accumulated Depreciation (book methods)	(12,888)		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): Due Others	(389,292)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (383,264)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 593,727	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,725	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,962		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	22,409		36
37	Due Others, Adv Billing	194,213		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 551,309	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 551,309	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 42,418	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 593,727	$	48

***(See instructions.)**

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 458,388	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 458,389	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,029	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (415,971)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 42,418	24 *

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,502,307	1
2	Discounts and Allowances for all Levels	(325,798)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,176,509	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,383,730	6
7	Oxygen	11,852	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,395,582	8
	C. Other Operating Revenue		
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		13
14	Non-Patient Meals	5,133	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,203	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,380	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,438	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 161,154	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 125	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending/Misc Income	2,251	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,251	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,735,621	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	732,118	31
32	Health Care	2,218,858	32
33	General Administration	1,083,644	33
	B. Capital Expense		
34	Ownership	418,191	34
	C. Ancillary Expense		
35	Special Cost Centers	142,388	35
36	Provider Participation Fee	56,393	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,651,592	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,029	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,029	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: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,183	$ 67,405	$ 30.88	1
2	Assistant Director of Nursing	2,029	2,141	57,936	27.06	2
3	Registered Nurses	12,124	12,561	348,088	27.71	3
4	Licensed Practical Nurses	13,524	14,271	326,119	22.85	4
5	CNAs & Orderlies	54,505	56,023	606,706	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,872	3,204	36,787	11.48	8
9	Activity Director	1,958	2,086	38,420	18.42	9
10	Activity Assistants	4,098	4,258	35,421	8.32	10
11	Social Service Workers	3,422	3,702	53,010	14.32	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,103	32,326	15.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,459	15,237	144,708	9.50	15
16	Dishwashers					16
17	Maintenance Workers	2,690	2,854	45,786	16.04	17
18	Housekeepers	9,571	9,954	86,358	8.68	18
19	Laundry	5,929	6,143	53,784	8.76	19
20	Administrator	1,944	2,463	74,904	30.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,728	7,619	142,027	18.64	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	1,814	2,124	40,065	18.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,650	148,926	$ 2,189,850 *	$ 14.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	157	$ 7,545	1-03	35
36	Medical Director	Monthly	13,728	9-03	36
37	Medical Records Consultant	Quarterly	1,840	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,759	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	48	2,400	11-03	44
45	Social Service Consultant	34	2,097	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	$ 31,369		49

C. CONTRACT NURSES

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

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ODELIA UNDERWOOD	ADMINISTRATOR		$ 44,149
JAMES BOYLE	ADMINISTRATOR		30,755
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 74,904

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 163,014
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 163,014

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,828
Unemployment Compensation Insurance	26,723
FICA Taxes	151,248
Employee Health Insurance	61,992
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	200
EMPLOYEE BENEFITS-OTHER	7,106
EMPLOYEE PHYSICAL EXAM	2,003
TOTAL (agree to Schedule V, line 22, col.8)	$ 360,100

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,550
Health Care Worker Background Check	2,672
(Indicate # of checks performed 24)	
Patient Background Checks 122	
ADVERTISING & MARKETING	28,830
DUES & SUBSCRIPTIONS	8,821
LICENSES	1,830
ALLOCATION FROM PLATINUM	667
Less: Public Relations Expense	( )
Non-allowable advertising	(28,830)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,540

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,141
ALLOCATION FROM PLATINUM	205
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,346

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RIVERSHORES CARE CENTER # 0049528 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RIVERSHORES CARE CENTER **#** 0049528 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 $8,961**

(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? **10-15 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,219** 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. $ **56,393**
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? **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?
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 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.