

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0052795</u></p> <p><b>Facility Name:</b> <u>River View Rehab Center</u></p> <p><b>Address:</b> <u>50 North Jane</u> <u>Elgin</u> <u>60123</u>          Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>(847) 697-3750</u> <b>Fax #</b> <u>(847) 697-5385</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>6/1/2014</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/14</u> to <u>12/31/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"><b>Paid Preparer</b></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>
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Facility Name & ID Number River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

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 N/A

	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	203	Skilled (SNF)	203	43,442	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	203	TOTALS	203	43,442	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	35,426	1,273	3,241	39,940	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,426	1,273	3,241	39,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.94%

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)  
None

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 06/01/2014

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/2014 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 203 and days of care provided 1,704

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name &amp; ID Number

River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

**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	165,415	23,978	10,199	199,592		199,592		199,592		1
2	Food Purchase		213,703		213,703		213,703	1,224	214,927		2
3	Housekeeping	133,668	18,643		152,311		152,311	929	153,240		3
4	Laundry	45,843	7,354		53,197		53,197		53,197		4
5	Heat and Other Utilities			94,023	94,023		94,023	(15,203)	78,820		5
6	Maintenance	66,785		37,993	104,778		104,778	(1,355)	103,423		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	411,711	263,678	142,215	817,604		817,604	(14,405)	803,199		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,510,359	11,340	10,213	1,531,912		1,531,912	(8,473)	1,523,439		10
10a	Therapy	46,597			46,597		46,597		46,597		10a
11	Activities	61,707	5,770	1,428	68,905		68,905		68,905		11
12	Social Services	157,340		1,512	158,852		158,852		158,852		12
13	CNA Training										13
14	Program Transportation			660	660		660		660		14
15	Other (specify):*							6,037	6,037		15
16	<b>TOTAL Health Care and Programs</b>	1,776,003	17,110	22,213	1,815,326		1,815,326	(2,436)	1,812,890		16
	<b>C. General Administration</b>										
17	Administrative	76,092		329,216	405,308		405,308	(296,190)	109,118		17
18	Directors Fees										18
19	Professional Services			56,245	56,245		56,245	(26,912)	29,333		19
20	Dues, Fees, Subscriptions & Promotions			19,192	19,192		19,192	(4,489)	14,703		20
21	Clerical & General Office Expenses	77,704		44,342	122,046		122,046	51,780	173,826		21
22	Employee Benefits & Payroll Taxes			296,847	296,847		296,847		296,847		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,285	1,285		1,285	406	1,691		24
25	Other Admin. Staff Transportation			92	92		92	3,788	3,880		25
26	Insurance-Prop.Liab.Malpractice			106,392	106,392		106,392	167	106,559		26
27	Other (specify):*							14,629	14,629		27
28	<b>TOTAL General Administration</b>	153,796		853,611	1,007,407		1,007,407	(256,820)	750,587		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,341,510	280,788	1,018,039	3,640,337		3,640,337	(273,661)	3,366,676		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 &amp; ID Number

River View Rehab Center

#0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			5,030	5,030	5,030	4,531	9,561				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			468	468	468	2,319	2,787				32
33	Real Estate Taxes			53,830	53,830	53,830	5,436	59,266				33
34	Rent-Facility & Grounds			583,498	583,498	583,498	0	583,498				34
35	Rent-Equipment & Vehicles			4,940	4,940	4,940		4,940				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			647,766	647,766	647,766	12,286	660,052				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,658	188,380	308,038	308,038		308,038				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,910	298,910	298,910		298,910				42
43	Other (specify):*			15,044	15,044	15,044	(15,044)					43
44	<b>TOTAL Special Cost Centers</b>		119,658	502,334	621,992	621,992	(15,044)	606,948				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,341,510	400,446	2,168,139	4,910,095	4,910,095	(276,419)	4,633,676				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 River View Rehab Center

# 0052795

Report Period Beginning: 06/01/14

Ending: 12/31/14

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,103)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,351	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		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	(546)	21		18
19	Entertainment				19
20	Contributions	(750)	20		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	(809)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,751)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (66,691)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(209,729)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (209,729)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (276,419)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

River View Rehab Center

ID# 0052795

Report Period Beginning: 06/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare Sequestration	\$ (7,441)	21	1
2	PAC Dues	(3,246)	20	2
3	Marketing Expense	(2,033)	43	3
4	Bank Charges	(5,829)	21	4
5	Capitalized R&M	(2,800)	06	5
6	Medical Record Income & Reimbursement	(68)	10	6
7	Non-Allowable Legal	(28,334)	19	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>		(49,751)	49

River View Rehab Center

ID# 0052795

Report Period Beginning: 06/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number River View Rehab Center# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(68)		1,201		91							1,224	2
3	Housekeeping			929									929	3
4	Laundry													4
5	Heat and Other Utilities	(16,103)		900									(15,203)	5
6	Maintenance	(2,800)		1,436		9							(1,355)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(18,971)</b>		<b>4,466</b>		<b>100</b>							<b>(14,405)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(68)				(8,405)							(8,473)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,037							6,037	15
16	<b>TOTAL Health Care and Programs</b>	<b>(68)</b>				<b>(2,368)</b>							<b>(2,436)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(298,047)		1,857							(296,190)	17
18	Directors Fees													18
19	Professional Services	(28,334)		242		1,180							(26,912)	19
20	Fees, Subscriptions & Promotions	(4,805)		143	139	34							(4,489)	20
21	Clerical & General Office Expenses	(13,816)		64,948		648							51,780	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			129		277							406	24
25	Other Admin. Staff Transportation					3,788							3,788	25
26	Insurance-Prop.Liab.Malpractice			167									167	26
27	Other (specify):*			13,651		978							14,629	27
28	<b>TOTAL General Administration</b>	<b>(46,955)</b>		<b>(218,767)</b>	<b>139</b>	<b>8,762</b>							<b>(256,820)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(65,994)</b>		<b>(214,301)</b>	<b>139</b>	<b>6,494</b>							<b>(273,661)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,351			3,179								4,531	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15)		11	2,323								2,319	32
33	Real Estate Taxes				5,436								5,436	33
34	Rent-Facility & Grounds			8,506	(8,506)								0	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>1,336</b>		<b>8,517</b>	<b>2,432</b>								<b>12,286</b>	<b>37</b>
	<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													42
43	Other (specify):*	(2,033)				(13,011)							(15,044)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,033)</b>				<b>(13,011)</b>							<b>(15,044)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(66,691)</b>		<b>(205,783)</b>	<b>2,571</b>	<b>(6,517)</b>							<b>(276,419)</b>	<b>45</b>

Facility Name & ID Number

River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2	DIETARY	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 1,201	\$ 1,201
16	V	3	HOUSEKEEPING	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	929	929
17	V	5	UTILITIES	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	900	900
18	V	6	REPAIRS AND MAINTENANCE	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,436	1,436
19	V	17	S WEBSTER SALARY	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	15,562	15,562
20	V	17	Y LEVOVITZ-SALARY	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	15,607	15,607
21	V	19	PROFESSIONAL FEES	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	242	242
22	V	20	DUES FEES SUBSCRIPTIONS	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	143	143
23	V	21	CLERICAL AND GENERAL	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	5,881	5,881
24	V	21	CLERICAL & GENERAL SALARIES	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	59,068	59,068
25	V	24	SEMINARS & EDUCATION	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	129	129
26	V	26	INSURANCE	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	167	167
27	V	27	EMPLOYEE BEN. GEN ADMIN.	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	13,651	13,651
28	V	32	INTEREST	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	11	11
29	V	34	RENT	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8,506	8,506
30	V						
31	V	17	MANAGEMENT FEES				(329,216)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 329,216			\$ 123,433	\$ * (205,783)

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

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning: 06/01/14

Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC		139	\$	139	15
16	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC		3,179		3,179	16
17	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC		2,323		2,323	17
18	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC		5,436		5,436	18
19	V								19
20	V	34 RENT	8,506					(8,506)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 8,506			\$ 11,077	\$ *	2,571	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 91	\$	91	15
16	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	9		9	16
17	V	10 NURSING SALARIES	62,975	iCare Consulting Services LLC	100.00%	54,570		(8,405)	17
18	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	6,037		6,037	18
19	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%	1,857		1,857	19
20	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	1,180		1,180	20
21	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	34		34	21
22	V	21 CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	2,621		2,621	22
23	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	6,985		6,985	23
24	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	277		277	24
25	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	3,788		3,788	25
26	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	978		978	26
27	V								27
28	V	21 ENVIRONMENTAL CONSULTANT	8,958					(8,958)	28
29	V	43 MARKETING CONSULTANT	13,011					(13,011)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 84,944			\$ 78,427	\$ *	(6,517)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	21.39%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO.	1
2	Yeruchom Levovitz	19.91%	CEDAR POINTE REHAB & NURSING	CICERO	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO.	2
3	Jeffrey Webster	5.30%	PARK VIEW REHAB CENTER	CHICAGO	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING	3
4	Eli Webster	2.46%	FOREST CITY REHAB & NURSING CENTE	ROCKFORD				4
5	EZ&A	2.46%	PINE CREST HEALTH CENTER	HAZEL CREST				5
6	Howard Wengrow	7.27%	ROCK RIVER HEALTH CARE	ROCKFORD				6
7	Jay Wengrow	1.48%						7
8	Dina Braunstein	1.48%						8
9	Moshe Levovitz	0.99%						9
10	Kevin Chankin	2.46%						10
11	Chaim Levovitz	0.99%						11
12	Yehuda Orlansky	0.49%						12
13	Atied Associates LLC	33.33%						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

Facility Name & ID Number

River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

## 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	Shimon Webster	Owner	Administrative	21.39%	See Attached	4.6	11.50%	Alloc Salary	\$ 15,562	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	19.91%	See Attached	4.6	11.50%	Alloc Salary	15,607	17-7	2
3	Yakov Kohen	Relative	A&G	0.00%	See Attached	4.6	11.50%	Alloc Salary	10,059	21-7	3
4	Kevin Chankin	Owner	A&G	2.46%	See Attached	4.6	11.50%	Alloc Salary	13,995	21-7	4
5	Moshe Levovitz	Owner	A&G	0.99%	See Attached	1.15	2.88%	Alloc Salary	398	21-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 55,621		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 River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PREMIER HEALTHCARE & FINANCIAL SER  
 Street Address 8153 N. LAWNDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

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

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	2	DIETARY	PATIENT DAYS	347,452	7	\$ 10,450	\$ 39,940	\$ 1,201	1	
2	3	HOUSEKEEPING	PATIENT DAYS	347,452	7	8,084	39,940	929	2	
3	5	UTILITIES	PATIENT DAYS	347,452	7	7,831	39,940	900	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	347,452	7	12,495	39,940	1,436	4	
5	17	S WEBSTER SALARY	PATIENT DAYS	347,452	7	135,377	135,377	39,940	15,562	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	347,452	7	135,768	135,768	39,940	15,607	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	347,452	7	2,104	39,940	242	7	
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	347,452	7	1,246	39,940	143	8	
9	21	CLERICAL AND GENERAL	PATIENT DAYS	347,452	7	51,157	39,940	5,881	9	
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	347,452	7	513,852	513,852	39,940	59,068	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	347,452	7	1,118	39,940	129	11	
12	26	INSURANCE	PATIENT DAYS	347,452	7	1,450	39,940	167	12	
13	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	347,452	7	118,755	39,940	13,651	13	
14	32	INTEREST	PATIENT DAYS	347,452	7	96	39,940	11	14	
15	34	RENT	PATIENT DAYS	347,452	7	74,000	39,940	8,506	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 1,073,783	\$ 784,997		\$ 123,433	25	

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PREMIER HC REAL ESTATE, LLC  
 Street Address 8153 N. LAWNSDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 751-2027

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

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	20	PROFESSIONAL FEES	PATIENT DAYS	347,452	7	1,210	39,940	139	1
2	30	DEPRECIATION	PATIENT DAYS	347,452	7	27,658	39,940	3,179	2
3	32	INTEREST EXPENSE	PATIENT DAYS	347,452	7	20,211	39,940	2,323	3
4	33	REAL ESTATE TAXES	PATIENT DAYS	347,452	7	47,288	39,940	5,436	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					\$ 96,367	\$	\$ 11,077	25

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization iCare Consulting Services LLC  
 Street Address 8153 N. LAWNSDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

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

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	2	DIETARY	PATIENT DAYS	5	\$ 676		39,940	\$ 91	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	5	68		39,940	9	2
3	10	NURSING SALARIES	PATIENT DAYS	5	407,152	407,152	39,940	54,570	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	5	45,046		39,940	6,037	4
5	17	ADMIN SALARY NON-RELAT	PATIENT DAYS	5	13,853		39,940	1,857	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	5	8,806		39,940	1,180	6
7	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	5	250		39,940	34	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	5	19,558	19,558	39,940	2,621	8
9	21	CLERICAL & GENERAL SALA	PATIENT DAYS	5	52,114		39,940	6,985	9
10	24	SEMINARS & EDUCATION	PATIENT DAYS	5	2,068		39,940	277	10
11	25	AUTO EXPENSE	PATIENT DAYS	5	28,266		39,940	3,788	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	5	7,298		39,940	978	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				\$ 585,155	\$ 426,710		\$ 78,427	25

Facility Name & ID Number River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

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 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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

# 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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



Facility Name & ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	Name of Lender	2		3	4	5	6		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							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	<b>TOTAL Long-Term</b>																
	<b>Working Capital</b>																
8							\$	\$			\$						
9																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Working Capital</b>																
	<b>B. Non-Facility Related*</b>																
15							\$	\$			\$						
16																	
17																	
18																	
19																	
20	<b>TOTAL Non-Facility Related</b>																

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 report.		\$	<u>38,399</u>		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.)		\$	<u>97,665</u>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>59,266</u>		3	
4. Real Estate Tax accrual used for 2014 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.		\$	<u>59,266</u>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<b>FOR BHF USE ONLY</b>			
	2010 _____	9				
	2011 _____	10				
	2012 _____	11				
	2013 <u>92,229</u>	12				
<u>Beginning accrual adjusted because the facility does not accrue for real estate taxes as they do not own the building.</u>			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
<u>Allocated From Premier: \$5,436</u>			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.**



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?      X   YES                  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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,780 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	<u>Allocated From Premier</u>			<u>2,184</u>	2
3	TOTALS			\$ 2,184	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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

\*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 River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<a href="#">Related Building Company (Pages 12F &amp; 12G)</a>								67
68	<a href="#">Related Party Allocations (Pages 12H &amp; 12I)</a>			127,575	3,109	5,345	2,236	16,452	68
69	<a href="#">Financial Statement Depreciation</a>				5,030		(5,030)		69
70	<b>TOTAL (lines 4 thru 69)</b>			\$ 127,575	\$ 8,139	\$ 5,345	\$ (2,794)	\$ 16,452	70

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		\$ 127,575	\$ 8,139		\$ 5,345	\$ (2,794)	\$ 16,452	1
2	New Pipes For Water Heater-Hall Between Kitchen/Linen Rm	2014	2,800		20	140	140	140	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	TOTAL (lines 1 thru 33)		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	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	TOTAL (lines 1 thru 33)		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	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	TOTAL (lines 1 thru 33)	\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	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	TOTAL (lines 1 thru 33)		\$ 130,375	\$ 8,139		\$ 5,485	\$ (2,654)	\$ 16,592	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	
1	Totals from Page 12E, Carried Forward			\$		\$				\$		\$		\$		1
2	Buildings:															2
3																3
4																4
5																5
6																6
7																7
8	Leasehold Improvements															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	TOTAL (lines 1 thru 33)			\$		\$				\$		\$		\$		34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12F, Carried Forward</b>								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated From Premier Realty	2011	42,809	1,098	35	1,223	125	3,770	3
4	Allocated From Premier Realty	2012	5,450	140	35	156	16	467	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated From Premier Healthcare & Financial Services	2012	971		20	49	49	146	9
10									10
11	Allocated From Premier Realty	2011	76,138	1,814	20	3,807	1,993	11,738	11
12	Allocated From Premier Realty	2012	2,207	57	20	110	53	331	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 127,575	\$ 3,109		\$ 5,345	\$ 2,236	\$ 16,452	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 127,575	\$ 3,109		\$ 5,345	\$ 2,236	\$ 16,452	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	TOTAL (lines 1 thru 33)	\$ 127,575	\$ 3,109		\$ 5,345	\$ 2,236	\$ 16,452	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 32,379	\$ 71	\$ 3,238	\$ 3,167	10	\$ 9,894	71
72	Current Year Purchases	8,383		838	838	10	838	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 40,762	\$ 71	\$ 4,076	\$ 4,005		\$ 10,732	75

D. Vehicle Costs. (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)	\$ 173,321	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,210	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,561	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,351	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 27,324	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Maplewood-Jane LLC

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:		<u>203</u>		\$ <u>583,498</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>203</b>		\$ <b>583,498</b>			<b>7</b>

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. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \$ 4,940

Description: See Attached Schedule

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

\* 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 River View Rehab Center # 0052795 Report Period Beginning: 06/01/14 Ending: 12/31/14  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	55,502	\$		\$	55,502	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				48,102				48,102	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				81,462				81,462	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 prescripts					51,627			51,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						3,314	68,031			71,345	13
14	<b>TOTAL</b>			\$		\$	188,380	\$	119,658	\$	308,038	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 River View Rehab Center# 0052795Report Period Beginning: 06/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 122,280	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,598,139		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,221		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	26,299		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,870,939	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,383		16
17	Accumulated Depreciation (book methods)	(5,030)		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):	1,023,740		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,027,093	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,898,032	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 385,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable	340,000		29
30	Accrued Salaries Payable	532,027		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,850		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	See Attached Schedule	66,416		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,337,072	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,337,072	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,560,960	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,898,032	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	748,960	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	(203,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>Capital Stock</b>	1,015,000	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,560,960	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,560,960	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,429,412	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,429,412	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,736	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 94,736	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	134,892	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 134,892	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,659,055	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	817,604	31
32	Health Care	1,815,326	32
33	General Administration	1,007,407	33
<b>B. Capital Expense</b>			
34	Ownership	647,766	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	323,082	35
36	Provider Participation Fee	298,910	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,910,095	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	748,960	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 748,960	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,446,505	44
45	Private Pay - Net Inpatient Revenue	232,870	45
46	Medicare - Net Inpatient Revenue	557,920	46
47	Other-(specify)	180,413	47
48	Other-(specify)	11,704	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,429,412	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,048	1,121	\$ 46,096	\$ 41.12	1
2	Assistant Director of Nursing	992	1,113	37,239	33.46	2
3	Registered Nurses	17,789	19,394	653,670	33.70	3
4	Licensed Practical Nurses	3,725	4,127	113,072	27.40	4
5	CNAs & Orderlies	40,270	41,565	625,664	15.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,698	3,113	46,597	14.97	8
9	Activity Director	984	1,035	17,988	17.38	9
10	Activity Assistants	4,510	4,703	43,719	9.30	10
11	Social Service Workers	10,573	11,724	157,340	13.42	11
12	Dietician					12
13	Food Service Supervisor	688	721	18,506	25.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,102	12,739	146,909	11.53	15
16	Dishwashers					16
17	Maintenance Workers	4,802	5,458	66,785	12.24	17
18	Housekeepers	11,353	12,295	133,668	10.87	18
19	Laundry	4,075	4,277	45,843	10.72	19
20	Administrator	1,064	1,221	55,418	45.39	20
21	Assistant Administrator	600	860	20,674	24.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,927	4,538	77,704	17.12	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	1,916	2,141	34,618	16.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,116	132,145	\$ 2,341,510 *	\$ 17.72	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	217	\$ 10,199	01-03	35
36	Medical Director	Monthly	8,400	09-03	36
37	Medical Records Consultant	Monthly	2,744	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	187	7,469	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	28	1,428	11-03	44
45	Social Service Consultant	24	1,512	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	456	\$ 31,752		49

**C. CONTRACT NURSES**

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



XIX-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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
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17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number River View Rehab Center

# 0052795

Report Period Beginning:

06/01/14

Ending:

12/31/14

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC \$9,835
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,037 Line 10-02
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 298,910  
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% ln14
- d. Have vehicle usage logs been maintained? No
- 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? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.