

Facility Name & ID Number River View Rehab Center

0052795 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	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	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	5 Total		
8	SNF	<u>59,202</u>	<u>2,028</u>	<u>5,478</u>	<u>66,708</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>59,202</u>	<u>2,028</u>	<u>5,478</u>	<u>66,708</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.03%

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 3,697

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

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River View Rehab Center

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Report Period Beginning:

01/01/15

Ending:

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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
	A. General Services										
1	Dietary	264,711	39,993	17,696	322,400		322,400		322,400		1
2	Food Purchase		332,644		332,644		332,644	1,315	333,959		2
3	Housekeeping	220,797	32,189		252,986		252,986	1,374	254,360		3
4	Laundry	77,145	15,746		92,891		92,891		92,891		4
5	Heat and Other Utilities			175,723	175,723		175,723	(20,970)	154,753		5
6	Maintenance	53,337		94,205	147,542		147,542	(27,500)	120,042		6
7	Other (specify):*										7
8	TOTAL General Services	615,990	420,572	287,624	1,324,186		1,324,186	(45,781)	1,278,405		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,549,828	24,288	15,032	2,589,148		2,589,148	(59,942)	2,529,206		10
10a	Therapy	84,890			84,890		84,890		84,890		10a
11	Activities	98,379	8,443	2,488	109,310		109,310		109,310		11
12	Social Services	261,865		1,952	263,817		263,817		263,817		12
13	CNA Training										13
14	Program Transportation			2,655	2,655		2,655		2,655		14
15	Other (specify):*							14,080	14,080		15
16	TOTAL Health Care and Programs	2,994,962	32,731	36,527	3,064,220		3,064,220	(45,862)	3,018,358		16
	C. General Administration										
17	Administrative	94,780		652,535	747,315		747,315	(607,738)	139,577		17
18	Directors Fees										18
19	Professional Services			79,984	79,984		79,984	(1,606)	78,378		19
20	Dues, Fees, Subscriptions & Promotions			54,674	54,674		54,674	(10,354)	44,320		20
21	Clerical & General Office Expenses	141,342		83,207	224,549		224,549	63,048	287,597		21
22	Employee Benefits & Payroll Taxes			506,220	506,220		506,220		506,220		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,665	1,665		1,665	1,370	3,035		24
25	Other Admin. Staff Transportation			2,136	2,136		2,136	8,121	10,257		25
26	Insurance-Prop.Liab.Malpractice			205,416	205,416		205,416	1,123	206,539		26
27	Other (specify):*							29,782	29,782		27
28	TOTAL General Administration	236,122		1,585,837	1,821,959		1,821,959	(516,254)	1,305,705		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,847,074	453,303	1,909,988	6,210,365		6,210,365	(607,897)	5,602,468		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

River View Rehab Center

#0052795

Report Period Beginning:

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Ending:

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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	
	D. Ownership											
30	Depreciation			1,174	1,174		1,174	13,081	14,255			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,388	3,388		3,388	1,866	5,254			32
33	Real Estate Taxes			104,640	104,640		104,640	5,782	110,422			33
34	Rent-Facility & Grounds			1,032,699	1,032,699		1,032,699	(0)	1,032,699			34
35	Rent-Equipment & Vehicles			1,859	1,859		1,859		1,859			35
36	Other (specify):*											36
37	TOTAL Ownership			1,143,760	1,143,760		1,143,760	20,728	1,164,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,809	691,799	904,608		904,608		904,608			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			495,465	495,465		495,465		495,465			42
43	Other (specify):*			31,328	31,328		31,328	(31,328)				43
44	TOTAL Special Cost Centers		212,809	1,218,592	1,431,401		1,431,401	(31,328)	1,400,073			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,847,074	666,112	4,272,340	8,785,526		8,785,526	(618,496)	8,167,030			45

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

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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	(22,120)	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	7,658	30		9
10	Interest and Other Investment Income	(935)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	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	(1,926)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,997)	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	(89,871)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (113,292)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(505,204)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (505,204)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (618,496)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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River View Rehab Center

ID# 0052795

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration	\$ (28,695)	21	1
2	PAC Dues	(9,763)	20	2
3	Marketing Expense	(2,737)	43	3
4	Bank Charges	(5,452)	21	4
5	Medical Record Income & Reimbursement	(460)	10	5
6	Non-Allowable Legal	(833)	19	6
7	Vending Income	(1,125)	02	7
8	Non-Allowable PY Professional Fees	(6,130)	21	8
9	Non-Allowable Marketing Prof Fee	(4,677)	19	9
10	Capitalized R&M	(30,000)	06	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	(89,871)		49

River View Rehab Center

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River View Rehab Center# 0052795

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(1,226)		2,340		201							1,315	2
3	Housekeeping			1,374									1,374	3
4	Laundry													4
5	Heat and Other Utilities	(22,120)		1,150									(20,970)	5
6	Maintenance	(30,000)		2,443		57							(27,500)	6
7	Other (specify):*													7
8	TOTAL General Services	(53,346)		7,307		258							(45,781)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(460)				(59,482)							(59,942)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,080							14,080	15
16	TOTAL Health Care and Programs	(460)				(45,402)							(45,862)	16
	C. General Administration													
17	Administrative			(613,533)		5,795							(607,738)	17
18	Directors Fees													18
19	Professional Services	(5,510)		1,171	173	2,560							(1,606)	19
20	Fees, Subscriptions & Promotions	(15,760)		5,334	36	36							(10,354)	20
21	Clerical & General Office Expenses	(42,203)		126,701		(21,451)							63,048	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			518		852							1,370	24
25	Other Admin. Staff Transportation			1,130		6,991							8,121	25
26	Insurance-Prop.Liab.Malpractice			1,123									1,123	26
27	Other (specify):*			27,099		2,683							29,782	27
28	TOTAL General Administration	(63,472)		(450,457)	209	(2,534)							(516,254)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,278)		(443,150)	209	(47,678)							(607,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River View Rehab Center# 0052795

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	7,658		1,457	3,966								13,081	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(935)			2,801								1,866	32
33	Real Estate Taxes				5,782								5,782	33
34	Rent-Facility & Grounds			13,335	(13,335)								(0)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	6,723		14,791	(786)								20,728	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(2,737)				(28,591)							(31,328)	43
44	TOTAL Special Cost Centers	(2,737)				(28,591)							(31,328)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(113,292)		(428,358)	(577)	(76,269)							(618,496)	45

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					
			\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 2,340	\$ 2,340
16	V	3					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,374	1,374
17	V	5					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,150	1,150
18	V	6					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,443	2,443
19	V	17					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	20,013	20,013
20	V	17					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	18,989	18,989
21	V	19					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,171	1,171
22	V	20					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	5,334	5,334
23	V	21					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	13,249	13,249
24	V	21					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	113,452	113,452
25	V	24					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	518	518
26	V	25					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,130	1,130
27	V	26					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,123	1,123
28	V	27					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	27,099	27,099
29	V	30					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,457	1,457
30	V	34					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	13,335	13,335
31	V						
32	V	17	652,535				(652,535)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 652,535			\$ 224,177	\$ * (428,358)

* 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: 01/01/15

Ending: 12/31/15

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	19 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	173	\$ 173
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	36	36
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	3,966	3,966
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,801	2,801
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	5,782	5,782
20	V	34 RENT	13,335				(13,335)
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 13,335			\$ 12,758	\$ * (577)

* 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%	\$ 201	\$ 201
16	V	3 HOUSEKEEPING		iCare Consulting Services LLC	100.00%		
17	V	5 UTILITIES		iCare Consulting Services LLC	100.00%		
18	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	57	57
19	V	10 NURSING SALARIES	177,315	iCare Consulting Services LLC	100.00%	117,833	(59,482)
20	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	14,080	14,080
21	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%		
22	V	17 M LEVOVITZ-SALARY		iCare Consulting Services LLC	100.00%	5,795	5,795
23	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	2,560	2,560
24	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	36	36
25	V	21 CLERICAL AND GENERAL	44,353	iCare Consulting Services LLC	100.00%	6,247	(38,106)
26	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	16,655	16,655
27	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	852	852
28	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	6,991	6,991
29	V	26 INSURANCE		iCare Consulting Services LLC	100.00%		
30	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	2,683	2,683
31	V	43 MARKETING	28,591				(28,591)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 250,259			\$ 173,990	\$ * (76,269)

* 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: 01/01/15

Ending: 12/31/15

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	Total		\$			\$	\$ *	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: 01/01/15

Ending: 12/31/15

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	Total		\$			\$	\$ *	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: 01/01/15

Ending: 12/31/15

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	Total		\$			\$	\$ *	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: 01/01/15

Ending: 12/31/15

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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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: 01/01/15

Ending: 12/31/15

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	Total		\$			\$	\$ *	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:

01/01/15

Ending:

12/31/15

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	5.78	14.45%	Alloc Salary	\$ 20,013	17-7	1	
2	Yeruchom Levovitz	Owner	Administrative	19.91%	See Attached	5.78	14.45%	Alloc Salary	18,989	17-7	2	
3	Kevin Chankin	Owner	Clerical	2.46%	See Attached	5.78	14.45%	Alloc Salary	20,879	21-7	3	
4	Moshe Levovitz	Owner	Clerical	0.99%	See Attached	1.45	3.63%	Alloc Salary	1,449	21-7	4	
5											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											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 61,330		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:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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

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	461,493	11	\$ 16,187	\$ 66,708	\$ 2,340	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11	9,503	66,708	1,374	2
3	5	UTILITIES	PATIENT DAYS	461,493	11	7,957	66,708	1,150	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	16,899	66,708	2,443	4
5	17	S WEBSTER SALARY	PATIENT DAYS	461,493	11	138,451	138,451	20,013	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	131,370	131,370	18,989	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	8,102	66,708	1,171	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	36,899	66,708	5,334	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	91,659	66,708	13,249	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	784,868	784,868	113,452	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	3,583	66,708	518	11
12	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	7,819	66,708	1,130	12
13	26	INSURANCE	PATIENT DAYS	461,493	11	7,768	66,708	1,123	13
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	187,476	66,708	27,099	14
15	30	DEPRECIATION	PATIENT DAYS	461,493	11	10,078	66,708	1,457	15
16	32	INTEREST	PATIENT DAYS	461,493	11		66,708		16
17	34	RENT	PATIENT DAYS	461,493	11	92,250	66,708	13,335	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,550,868	\$ 1,054,689	\$ 224,177	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	1,195	66,708	173	1
2	20	LICENSES & PERMITS	PATIENT DAYS	461,493	11	250	66,708	36	2
3	30	DEPRECIATION	PATIENT DAYS	461,493	11	27,440	66,708	3,966	3
4	32	INTEREST EXPENSE	PATIENT DAYS	461,493	11	19,378	66,708	2,801	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	461,493	11	40,000	66,708	5,782	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					\$ 88,263	\$	\$ 12,758	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 iCare Consulting Services LLC
 Street Address 8153 N. Lawndale
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V	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	
Line Reference									
1	2	DIETARY	PATIENT DAYS	461,493	11	\$ 1,393	\$ 66,708	\$ 201	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11		66,708		2
3	5	UTILITIES	PATIENT DAYS	461,493	11		66,708		3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	391	66,708	57	4
5	10	NURSING SALARIES	PATIENT DAYS	461,493	11	815,183	815,183	66,708	117,833
6	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	461,493	11	97,410	66,708	14,080	6
7	17	ADMIN SALARY NON-RELATI	PATIENT DAYS	461,493	11		66,708		7
8	17	M LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	40,090	40,090	66,708	5,795
9	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	17,714	66,708	2,560	9
10	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	250	66,708	36	10
11	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	43,215	66,708	6,247	11
12	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	115,221	115,221	66,708	16,655
13	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	5,896	66,708	852	13
14	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	48,366	66,708	6,991	14
15	26	INSURANCE	PATIENT DAYS	461,493	11		66,708		15
16	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	18,559	66,708	2,683	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,203,688	\$ 970,494	\$ 173,990	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	MB Financial		X							3,388	6							
7	Allocated From Premier RE		X							2,801	7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 6,189	9							
B. Non-Facility Related*																		
10	Interest Income		X							(935)	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ (935)	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 5,254	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number

River View Rehab Center

0052795

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$	1					
2													2					
3													3					
4													4					
5													5					
6													6					
7	TOTAL Long-Term																	
	Working Capital																	
8							\$	\$				\$	8					
9													9					
10													10					
11													11					
12													12					
13													13					
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15							\$	\$				\$	15					
16													16					
17													17					
18													18					
19													19					
20	TOTAL Non-Facility Related																	

* 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	6,154		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.)		\$	116,576		2
3. Under or (over) accrual (line 2 minus line 1).		\$	110,422		3
4. Real Estate Tax accrual used for 2015 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. (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.		\$	110,422		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	_____			8
	2011	_____			9
	2012	_____			10
	2013	92,229			11
	2014	110,794			12
Beginning accrual adjusted because the facility does not accrue for real estate taxes as they do not own the building.					
Allocated From Premier: \$5,782					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

Facility Name & ID Number River View Rehab Center

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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>2,746</u>	2
3	TOTALS			\$ <u>2,746</u>	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
	Improvement Type**										
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

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Ending:

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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								67		
68			160,423	3,920	6,721	2,801	27,409	68		
69				(279)		279		69		
70		\$	160,423	\$	3,641	\$	3,080	\$	27,409	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		\$ 160,423	\$ 3,641		\$ 6,721	\$ 3,080	\$ 27,409	1
2	New Pipes For Water Heater-Hall Between Kitchen/Linen Room	2014	2,800		20	140	140	175	2
3	3 Hvac Rooftop Units (Out Of 12)	2015	30,000		20	1,500	1,500	1,500	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)		\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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		\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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)	\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	34

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

Facility Name & ID Number River View Rehab Center

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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		\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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)	\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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		\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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)	\$ 193,223	\$ 3,641		\$ 8,361	\$ 4,720	\$ 29,084	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	Building Company		\$	\$		\$	\$	\$	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	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

**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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	53,831	1,380	35	1,538	158	6,279	3
4	Allocated From Premier Realty	2012	6,854	176	35	196	20	783	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Premier Realty	2011	95,742	2,282	20	4,787	2,505	19,547	9
10	Allocated From Premier Realty	2012	2,775	71	20	139	68	555	10
11									11
12	Allocated From Premier Healthcare & Financial Services	2012	1,221	11	20	61	50	245	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)		\$ 160,423	\$ 3,920		\$ 6,721	\$ 2,801	\$ 27,409	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		\$ 160,423	\$ 3,920		\$ 6,721	\$ 2,801	\$ 27,409	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)	\$ 160,423	\$ 3,920		\$ 6,721	\$ 2,801	\$ 27,409	34

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

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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	\$ 49,099	\$ 1,511	\$ 5,749	\$ 4,238	10	\$ 19,028	71
72	Current Year Purchases	1,445	1,445	145	(1,300)	10	145	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 50,544	\$ 2,956	\$ 5,894	\$ 2,938		\$ 19,173	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)	\$ 246,513	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,255	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,658	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,257	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? YES NO

If NO, see instructions.

		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:		203		\$ 1,032,699			3
4	Additions							4
5								5
6								6
7	TOTAL		203		\$ 1,032,699			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 1,859 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	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 366,829	\$		\$ 366,829	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			317,935			317,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				121,779		121,779	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>					7,035	91,030		98,065	13
14	TOTAL			\$		\$ 691,799	\$ 212,809		\$ 904,608	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: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 843,368	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,251,486		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,132		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	97,917		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,331,903	\$	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			15
16	Equipment, at Historical Cost	8,383		16
17	Accumulated Depreciation (book methods)	(6,204)		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):	1,030,540		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,032,719	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,364,622	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 522,318	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,670		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	381,762		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,635		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
Other Current Liabilities(specify):				
36	See Attached Schedule	67,669		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,004,054	\$	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)	\$ 1,004,054	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,360,568	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,364,622	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,560,960	1
2	Restatements (describe):		2
3	Rounding	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,560,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,016,101	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	(1,216,500)	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)	\$ 799,601	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)	\$ 2,360,568	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/15

Ending:

12/31/15

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,153,356	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,153,356	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	414,260	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 414,260	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	935	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 935	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	233,076	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 233,076	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,801,627	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,324,186	31
32	Health Care	3,064,220	32
33	General Administration	1,821,959	33
B. Capital Expense			
34	Ownership	1,143,760	34
C. Ancillary Expense			
35	Special Cost Centers	935,936	35
36	Provider Participation Fee	495,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,785,526	40
41	Income before Income Taxes (line 30 minus line 40)**	2,016,101	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,016,101	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,908,594	44
45	Private Pay - Net Inpatient Revenue	419,065	45
46	Medicare - Net Inpatient Revenue	1,424,026	46
47	Other-(specify) <u>Hospice</u>	232,200	47
48	Other-(specify) <u>Veteran</u>	169,471	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,153,356	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

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,048	2,169	\$ 90,375	\$ 41.67	1
2	Assistant Director of Nursing	4,451	4,994	167,089	33.46	2
3	Registered Nurses	29,855	35,385	1,087,253	30.73	3
4	Licensed Practical Nurses	8,866	10,128	232,817	22.99	4
5	CNAs & Orderlies	69,787	76,093	918,165	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,172	6,206	84,890	13.68	8
9	Activity Director	1,324	1,394	22,404	16.07	9
10	Activity Assistants	8,657	9,026	75,975	8.42	10
11	Social Service Workers	19,858	21,389	261,865	12.24	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,360	41,705	17.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,451	24,209	223,006	9.21	15
16	Dishwashers					16
17	Maintenance Workers	3,834	4,358	53,337	12.24	17
18	Housekeepers	21,118	22,887	220,797	9.65	18
19	Laundry	7,808	8,367	77,145	9.22	19
20	Administrator	1,968	2,161	94,780	43.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,357	8,048	141,342	17.56	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	3,669	4,277	54,129	12.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,207	243,451	\$ 3,847,074 *	\$ 15.80	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	377	\$ 17,696	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant	Monthly	4,792	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	256	10,240	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	49	2,488	11-03	44
45	Social Service Consultant	31	1,952	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	713	\$ 51,568		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

Facility Name & ID Number River View Rehab Center

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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 \$29,584
- (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. \$ 9,835 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. \$ 495,465
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.