FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0052043

Facility Name: RIVER OAKS HEALTHCARE REHAB CENTER

Address: 14500 SOUTH MANISTEE (Number) BURNHAM (City) 60633 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/12

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,396	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	113,094	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	33,439		10,953	44,392	8
9	SNF/PED					9
10	ICF	63,950	31	585	64,566	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	97,389	31	11,538	108,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.34%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/12

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 10,876

Medicare Intermediary WISCONSIN PHYSICIANS SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CE # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	438,396	56,659	16,649	511,704		511,704	1,569	513,273			1
2	Food Purchase		563,970		563,970	(12,298)	551,672	(872)	550,800			2
3	Housekeeping	543,124	92,399		635,523		635,523		635,523			3
4	Laundry	125,748	42,935	11,065	179,748		179,748		179,748			4
5	Heat and Other Utilities			219,327	219,327		219,327	562	219,889			5
6	Maintenance	245,733	83,221	91,328	420,282		420,282	10,919	431,201			6
7	Other (specify):* SECURITY	198,474		113,218	311,692		311,692	296	311,988			7
8	TOTAL General Services	1,551,475	839,184	451,587	2,842,246	(12,298)	2,829,948	12,474	2,842,422			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	4,139,341	182,904	24,732	4,346,977		4,346,977	5,561	4,352,538			10
10a	Therapy	169,541		39,192	208,733		208,733		208,733			10a
11	Activities	152,264	34,636	3,285	190,185		190,185		190,185			11
12	Social Services	286,828		4,929	291,757		291,757		291,757			12
13	CNA Training											13
14	Program Transportation			11,439	11,439		11,439		11,439			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,747,974	217,540	89,577	5,055,091		5,055,091	5,561	5,060,652			16
	C. General Administration											
17	Administrative	134,069		951,000	1,085,069		1,085,069	(860,061)	225,008			17
18	Directors Fees											18
19	Professional Services			180,785	180,785		180,785	27,239	208,024			19
20	Dues, Fees, Subscriptions & Promotions			28,878	28,878		28,878	(6,187)	22,691			20
21	Clerical & General Office Expenses	234,928	41,787	133,266	409,981		409,981	(100,624)	309,357			21
22	Employee Benefits & Payroll Taxes			1,258,965	1,258,965	12,298	1,271,263		1,271,263			22
23	Inservice Training & Education			3,145	3,145		3,145	86	3,231			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			33,127	33,127		33,127	3,964	37,091			25
26	Insurance-Prop.Liab.Malpractice			233,711	233,711		233,711	31,559	265,270			26
27	Other (specify):*			353,187	353,187		353,187	(331,608)	21,579			27
28	TOTAL General Administration	368,997	41,787	3,176,064	3,586,848	12,298	3,599,146	(1,235,632)	2,363,514			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,668,446	1,098,511	3,717,228	11,484,185		11,484,185	(1,217,597)	10,266,588			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#: RIVER OAKS HEALTHCARE REHAB CENTER #0052043 **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,649	
	REPAIRS & MAINTENANCE		0	
			0	16,649
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		11,065	
			0	11,065
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		50,501	
	ELECTRICITY		89,590	
	WATER		71,738	
	CABLE TV - LOBBY		7,498	
			0	219,327
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,405	
	PAINTING & DECORATING		5,510	
	BUILDING REPAIRS		14,430	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		34,276	
	ELEVATOR MAINTENANCE & REPAIR		12,613	
	OUTSIDE LABOR		590	
	EXTERMINATING SERVICE		6,570	
	FIRE SERVICE		6,934	
			0	
			0	
			0	
			0	91,328
7	**OTHER**			
	SCAVENGER		26,254	
	SECURITY SERVICE		86,964	
			0	
			0	113,218
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	14,832	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,900	
			0	24,732
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		332	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	38,860	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				39,192
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,285	
			0	3,285
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,929	
	SOCIAL WORKER	XVIII B 45-2	0	
				4,929
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER **#0052043** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		11,439	11,439
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	951,000	951,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,272	
	ADMINISTRATIVE CONSULTANTS	XIX C	1,050	
	PROFESSIONAL FEES	XIX C	155,463	
			0	180,785
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,300	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	5,562	
	LICENSES & PERMITS	XIX F	6,812	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	6,674	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	4,530	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				28,878
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		908	
	EQUIPMENT REPAIR & MAINTENANCE		5,396	
	OUTSIDE CLERICAL SERVICES		107,708	
	PENALTIES / OVERDRAFT CHARGES	VI 18	84	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,170	
	MESSENGER SERVICE		0	
			0	133,266

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	504,434	
	UNEMPLOYMENT COMPENSATION	XIX D	198,028	
	WORKERS COMPENSATION INSURANC	XIX D	187,565	
	HOSPITALIZATION INSURANCE	XIX D	295,136	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,675	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	70,127	
	CHICAGO HEAD TAX	XIX D	0	
			0	1,258,965
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,145	
				3,145
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		33,127	
				33,127
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		233,711	
				233,711
27	**OTHER**			
	BAD DEBTS	VI 24	353,187	
				353,187

GRAND TOTAL COLUMN 3 OTHER **3,717,228**

RIVER OAKS HEALTHCARE REHAB CENTER
SCHEDULES
12/31/2012

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	563,970
LESS SALES TAX	(872)
NET FOOD	563,098
TOTAL PATIENT CENSUS	108,958
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	326,874
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	7,320
PATIENT MEALS	326,874
ADD EMPLOYEE MEALS	7,320
TOTAL MEALS/YEAR	334,194
NET FOOD	563,098
DIVIDE TOTAL MEALS/YEAR	334,194
COST PER MEAL	1.68
TIMES EMPLOYEE MEALS	7,320
EMPLOYEE MEAL RECLASSIFICATION	**12,298**

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER #0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,842	18,842		18,842	396,544	415,386			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,289	65,289		65,289	768,212	833,501			32
33	Real Estate Taxes							1,135,001	1,135,001			33
34	Rent-Facility & Grounds			2,497,000	2,497,000		2,497,000	(2,495,924)	1,076			34
35	Rent-Equipment & Vehicles			81,576	81,576		81,576	5,012	86,588			35
36	Other (specify):* IME			24,702	24,702		24,702	46,521	71,223			36
37	**TOTAL Ownership**			2,687,409	2,687,409		2,687,409	(144,634)	2,542,775			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		381,466	621,333	1,002,799		1,002,799		1,002,799			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,053,124	1,053,124		1,053,124		1,053,124			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		381,466	1,674,457	2,055,923		2,055,923		2,055,923			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,668,446	1,479,977	8,079,094	16,227,517		16,227,517	(1,362,231)	14,865,286			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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,121	30		9
10	Interest and Other Investment Income	(56)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(872)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(84)	21		18
19	Entertainment		20		19
20	Contributions	(7,674)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(353,187)	27		24
25	Fund Raising, Advertising and Promotional	(4,300)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(65,515)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (428,567)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(933,664)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (933,664)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,362,231)		37

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

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

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

STATE OF ILLINOIS

RIVER OAKS HEALTHCARE REHAB CENTER

ID# 0052043

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (64,350)	21	1
2	MARKETING AUTO LEASES	(1,165)	35	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,515)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	1,569	0	0	0	0	0	1,569	1
2	Food Purchase	(872)	0	0	0	0	0	0	0	0	0	0	(872)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	562	0	0	0	0	0	0	0	0	0	562	5
6	Maintenance	0	1,302	6,447	3,170	0	0	0	0	0	0	0	10,919	6
7	Other (specify):*	0	0	0	296	0	0	0	0	0	0	0	296	7
8	**TOTAL General Services**	(872)	1,864	6,447	3,466	0	1,569	0	0	0	0	0	12,474	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	5,561	0	0	0	0	0	5,561	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	5,561	0	0	0	0	0	5,561	16
	C. General Administration													
17	Administrative	0	0	(799,714)	19,653	0	(80,000)	0	0	0	0	0	(860,061)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	123	1,931	10,907	12,500	1,778	0	0	0	0	0	27,239	19
20	Fees, Subscriptions & Promotions	(11,974)	81	0	3,264	0	2,442	0	0	0	0	0	(6,187)	20
21	Clerical & General Office Expenses	(64,434)	0	14,092	(52,104)	0	1,822	0	0	0	0	0	(100,624)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	86	0	0	0	0	0	86	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	448	3,106	0	410	0	0	0	0	0	3,964	25
26	Insurance-Prop.Liab.Malpractice	0	134	2,462	758	28,095	110	0	0	0	0	0	31,559	26
27	Other (specify):*	(353,187)	0	10,641	9,137	0	1,801	0	0	0	0	0	(331,608)	27
28	**TOTAL General Administration**	(429,595)	338	(770,140)	(5,279)	40,595	(71,551)	0	0	0	0	0	(1,235,632)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(430,467)	2,202	(763,693)	(1,813)	40,595	(64,421)	0	0	0	0	0	(1,217,597)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,121	2,178	0	506	390,739	0	0	0	0	0	0	396,544	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56)	2,956	0	0	765,312	0	0	0	0	0	0	768,212	32
33	Real Estate Taxes	0	4,779	0	0	1,130,222	0	0	0	0	0	0	1,135,001	33
34	Rent-Facility & Grounds	0	0	0	0	(2,497,000)	1,076	0	0	0	0	0	(2,495,924)	34
35	Rent-Equipment & Vehicles	(1,165)	1,156	1,077	3,836	0	108	0	0	0	0	0	5,012	35
36	Other (specify):*	0	(24,702)	0	0	71,223	0	0	0	0	0	0	46,521	36
37	TOTAL Ownership	1,900	(13,633)	1,077	4,342	(139,504)	1,184	0	0	0	0	0	(144,634)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(428,567)	(11,431)	(762,616)	2,529	(98,909)	(63,237)	0	0	0	0	0	(1,362,231)	45

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	OFFICE RENT	$ 24,702	IME REALTY CORP.		$	$ (24,702)	1
2	V	5	UTILITIES				562	562	2
3	V	6	REPAIRS/MAINT				1,302	1,302	3
4	V	19	ACCOUNTING FEES				123	123	4
5	V	20	LICENSES & PERMITS				81	81	5
6	V	26	INSURANCE				134	134	6
7	V	30	DEPRECIATION (SL)				2,178	2,178	7
8	V	32	INTEREST				2,956	2,956	8
9	V	33	RE TAX				4,779	4,779	9
10	V	35	STORAGE FEES				1,156	1,156	10
11	V								11
12	V								12
13	V								13
14	Total			$ 24,702			$ 13,271	$ * (11,431)	14

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 871,000	EMI ENTERPRISES, INC		$	$ (871,000)	15
16	V	6	DRIVERS SALARIES				6,447	6,447	16
17	V	17	OFFICER SALARIES				41,096	41,096	17
18	V	17	REGIONAL DIRECTOR				685	685	18
19	V	17	MANAGEMENT CONSULTANT				29,505	29,505	19
20	V	19	ACCOUNTING FEES				1,931	1,931	20
21	V	21	TOTAL OFFICE				14,092	14,092	21
22	V	25	TRANSPORTATION				448	448	22
23	V	26	INSURANCE				2,462	2,462	23
24	V	27	EMPLOYEE BENEFITS				10,641	10,641	24
25	V	35	AUTO LEASE				1,077	1,077	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			$ 871,000			$ 108,384	$ * (762,616)	39

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 107,708	EKS MANAGEMENT CO.		$	$ (107,708)	15
16	V	6	PAINTERS SALARIES				3,170	3,170	16
17	V	7	SCAVENGER				296	296	17
18	V	17	CFO SALARY-A.WEINFELD				19,653	19,653	18
19	V	19	PROFESSIONAL FEES				10,907	10,907	19
20	V	20	WANT ADS/BACKGR CKS				3,264	3,264	20
21	V	21	TOTAL OFFICE				55,604	55,604	21
22	V	25	TRANSPORTATION				3,106	3,106	22
23	V	26	INSURANCE				758	758	23
24	V	27	EMPLOYEE BENEFITS				9,137	9,137	24
25	V	30	DEPRECIATION (SL)				506	506	25
26	V	35	EQUIPMENT RENT				3,836	3,836	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			$ 107,708			$ 110,237	$ * 2,529	39

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 2,497,000	BURNHAM HEALTH CARE REALTY LLC		$	$ (2,497,000)	15
16	V	19	PROFESSIONAL FEES				12,500	12,500	16
17	V	26	INSURANCE				28,095	28,095	17
18	V	30	DEPRECIATION				390,739	390,739	18
19	V	32	INTEREST				758,670	758,670	19
20	V	32	AMORT LOAN COST				6,642	6,642	20
21	V	33	REAL ESTATE TAXES				1,130,222	1,130,222	21
22	V	36	M.I.P. INSURANCE				71,223	71,223	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			$ 2,497,000			$ 2,398,091	$ * (98,909)	39

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 80,000	BRIA HEALTH SERVICES, LLC		$	$ (80,000)	15
16	V	1	DIETARY SALARIES				1,569	1,569	16
17	V	10	NURSING SALARIES				5,561	5,561	17
18	V	19	PROFESSIONAL FEES				1,778	1,778	18
19	V	20	WANT ADS				452	452	19
20	V	21	TOTAL OFFICE				1,287	1,287	20
21	V	21	CLERICAL SALARIES				535	535	21
22	V	23	SEMINARS				86	86	22
23	V	25	TRANSPORTATIONAL STAFF				410	410	23
24	V	26	INSURANCE				110	110	24
25	V	27	EMPLOYEE BENEFITS				1,801	1,801	25
26	V	34	OFFICE RENT				1,076	1,076	26
27	V	35	AUTO LEASE				108	108	27
28	V	20	LICENSES FEES				1,990	1,990	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			$ 80,000			$ 16,763	$ * (63,237)	39

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	AVRUM WEINFELD	23.75	ATRIUM HEALTHCARE & REHAB	COHOKIA	EKS MANAGEMENT	LINCOLNWOOD	HOME OFFICE	2
3								3
4	DANIEL WEISS	23.75	FOREST EDGE HEALTHCARE REHAB	CHICAGO	IME REALTY CORP	LINCOLNWOOD	MGMT CONSULT	4
5								5
6	NATAN WEISS	23.75	BELLEVILLE HEALTHCARE & REHAB	BELLEVILLE	EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT	6
7								7
8	FRED BERKOVITS	23.75	GENEVA NURSING & REHAB	GENEVA	BRIA HEALTH		MANAGEMENT	8
9					SERVICES, LLC	LINCOLNWOOD		9
10	DOV SEGAL	5.00	WESTMONT NURSING & REHAB	WESTMONT				10
11					BURNAM HEALTH		REAL ESTATE	11
12			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO	CARE REALTY	LINCOLNWOOD		12
13				HEIGHTS				13
14								14
15			PALOS HILLS HEALTHCARE	PALOS HILLS				15
16								16
17			LAKEPARK	WAUKEGAN				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 OAKS HEALTHCARE REHAB CI # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Alloc from Emi Entertprises:								$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	0.00	SEE ATTACHED	6	7.50	SALARY	41,096	17-7	2
3	MICHAEL ROSEN	Regional Director	Administrative	0.00	SCHEDULE			SALARY	685	17-7	3
4	PHILIP ESFORMES	Admin Consultant	Administrative	0.00		5	7.58	CONS. FEE	29,505	17-7	4
5											5
6	Alloc from Eks Management:										6
7	AVRUM WEINFELD	CFO	CFO	23.75		3	4.62	SALARY	19,656	17-7	7
8	FLORA WEISS	o/s consulting	Bookkeeping	0.00		0.5	0.89	CONS. FEE	2,616	21-7	8
9											9
10	ALLOCATION FR BRIA HEALTH SERVICES										10
11	DOV SEGAL	Purchasing Consult	CONSULTING					SALARY	1,762	19-7	11
12											12
13								TOTAL	$ 95,320		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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EMI ENTERPRISES, INC
Street Address: 6865 N . LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD ,IL.60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	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	6	DRIVERS SALARY	PATIENT DAYS	434,638	13	$ 30,591	$ 30,591	91,600	$ 6,447	1
2	17	OFFICER SALARY	PATIENT DAYS	434,638	13	195,000	195,000	91,600	41,096	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	434,638	13	3,250	3,250	91,600	685	3
4	17	MGT CONSULTANT	PATIENT DAYS	434,638	13	140,001		91,600	29,505	4
5	19	ACCUNTING FEES	PATIENT DAYS	434,638	13	9,162		91,600	1,931	5
6	21	TOTAL OFFICE	PATIENT DAYS	434,638	13	66,865	41,917	91,600	14,092	6
7	25	TRANSPORTATION	PATIENT DAYS	434,638	13	2,127		91,600	448	7
8	26	INSURANCE	PATIENT DAYS	434,638	13	11,682		91,600	2,462	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	434,638	13	50,493		91,600	10,641	9
10	35	AUTO LEASE	PATIENT DAYS	434,638	13	5,109		91,600	1,077	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					$ 514,280	$ 270,758		$ 108,384	25

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EKS MANAGEMENT, INC.
Street Address: 6865 N . LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD ,IL.60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	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	6	PAINTERS SALARIES	PATIENT DAYS	584,290	16	$ 17,002	$ 17,002	108,958	$ 3,170	1
2	7	SCAVENGER	PATIENT DAYS	584,290	16	1,589		108,958	296	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	584,290	16	105,390	105,390	108,958	19,653	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	584,290	16	58,487	48,494	108,958	10,907	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	584,290	16	17,500		108,958	3,264	5
6	21	TOTAL OFFICE	PATIENT DAYS	584,290	16	298,180	206,170	108,958	55,604	6
7	25	TRANSPORTATION	PATIENT DAYS	584,290	16	16,652		108,958	3,106	7
8	26	INSURANCE	PATIENT DAYS	584,290	16	4,061		108,958	758	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	584,290	16	48,997		108,958	9,137	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	584,290	16	2,710		108,958	506	10
11	35	EQUIPMENT RENT	PATIENT DAYS	584,290	16	20,572		108,958	3,836	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					$ 591,140	$ 377,056		$ 110,237	25

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 675-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	193,277	14	$ 4,400	$	24,702	$ 562	1
2	6	REPAIRS / MAINTENCE	RENTAL INCOME	193,277	14	10,190		24,702	1,302	2
3	19	ACCOUNTING FEES	RENTAL INCOME	193,277	14	962		24,702	123	3
4	20	LICENSE & PERMITS	RENTAL INCOME	193,277	14	632		24,702	81	4
5	26	INSURANCE	RENTAL INCOME	193,277	14	1,045		24,702	134	5
6	30	SL DEPRECIATION	RENTAL INCOME	193,277	14	17,044		24,702	2,178	6
7	32	INTEREST	RENTAL INCOME	193,277	14	23,132		24,702	2,956	7
8	33	REAL ESTATE TAX	RENTAL INCOME	193,277	14	37,391		24,702	4,779	8
9	35	STORAGE FEES	RENTAL INCOME	193,277	14	9,043		24,702	1,156	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					$ 103,839	$		$ 13,271	25

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: BRIA HEALTH SERVICES, LLC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	DIETARY SALARIES	PATIENT CENSUS	322,729	8	$ 29,170	$ 29,170	17,358	$ 1,569	1
2	10	NURSING SALARIES	PATIENT CENSUS	322,729	8	103,388	103,388	17,358	5,561	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	322,729	8	33,054	32,765	17,358	1,778	3
4	20	WANT ADS	PATIENT CENSUS	322,729	8	8,400		17,358	452	4
5	21	TOTAL OFFICE	PATIENT CENSUS	322,729	8	23,931		17,358	1,287	5
6	21	CLERICAL SALARIES	PATIENT CENSUS	322,729	8	9,940	9,940	17,358	535	6
7	23	SEMINARS	PATIENT CENSUS	322,729	8	1,599		17,358	86	7
8	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	322,729	8	7,616		17,358	410	8
9	26	INSURANCE	PATIENT CENSUS	322,729	8	2,036		17,358	110	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	322,729	8	33,481		17,358	1,801	10
11	34	OFFICE RENT	PATIENT CENSUS	322,729	8	20,000		17,358	1,076	11
12	35	AUTO LEASE	PATIENT CENSUS	322,729	8	2,000		17,358	108	12
13	20	LICENSES FEES	PATIENT CENSUS	35,314	2	3,980		17,358	1,990	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					$ 278,595	$ 175,263		$ 16,763	25

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CE] # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	B.WEINFELD	X		WORKING CAPITAL	$2,500.00	11/1/12	$ 200,000	$ 199,848	10/01/32	0.1409	$ 2,348	1
2	S.SEGAL	X		WORKING CAPITAL	$1,590.00	11/1/12	150,000	149,035	11/01/22	0.0500	625	2
3	MEMBERS -BYB	X		WORKING CAPITAL	$15,000.00	11/1/12	750,000	738,438	08/01/17	0.0550	3,438	3
4												4
5												5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL	INTEREST	REVOLV	758,000	758,000			7,204	6
7	PRIVATE BANK	X		WORKING CAPITAL	INTEREST	REVOLV					51,674	7
8												8
9	TOTAL Facility Related				$19,090.00		$ 1,858,000	$ 1,845,321			$ 65,289	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,858,000	$ 1,845,321			$ 65,289	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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 OAKS HEALTHCARE REHAB CE] # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BURNHAM HEALTH CARE REALTY						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$85,698.11	11/21/03	16,088,500	14,120,643	9/1/37	0.0533	758,670	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							6,642	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$85,698.11		$ 16,088,500	$ 14,120,643			$ 765,312	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,088,500	$ 14,120,643			$ 765,312	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 71,223** **Line #** **36**

*** 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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 570,666	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.)		$ 850,444	2
3. Under or (over) accrual (line 2 minus line 1).		$ 279,778	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 850,444	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.		$ 1,130,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	658,187	8
	2008	683,099	9
	2009	542,430	10
	2010	556,776	11
	2011	850,444	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER OAKS HEALTHCARE REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0052043

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-06-313-040-0000	NURSING HOME	$ 692,046.11	$ 692,046.11
2.	30-06-313-045-0000	NURSING HOME	$ 3,465.56	$ 3,465.56
3.	30-06-313-051-0000	NURSING HOME	$ 34,754.07	$ 34,754.07
4.	30-06-313-052-0000	NURSING HOME	$ 6,597.58	$ 6,597.58
5.	30-06-313-053-0000	NURSING HOME	$ 7,644.83	$ 7,644.83
6.	30-06-313-053-0000	NURSING HOME	$ 105,936.00	$ 105,936.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 850,444.15	$ 850,444.15

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (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).

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1998	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		$ 12,649,700	$ 324,351	39	$ 324,351	$	$ 4,788,287	4
5											5
6											6
7											7
8	IME ALLOCATIONS				71,100	2,056		2,056			8
	Improvement Type**										
9	ROOF - REALTY			1998	74,000	1,897	39	1,897		27,218	9
10	WALLCOVERINGS - REALTY			1998	39,379	1,010	39	1,010		14,487	10
11	PAINTING - REALTY			1998	12,962	332	39	332		4,766	11
12	WINDOW TREATMENTS - REALTY			1998	38,112	977	39	977		14,018	12
13	FENCE - REALTY			1998	650	17	39	17		241	13
14	NEW WINDOWS - REALTY			1998	20,445	524	39	524		7,519	14
15	PAINTERS SALARIES - REALTY			1998	64,064	1,643	39	1,643		23,568	15
16	NURSE STATION - REALTY			1998	23,100	592	39	592		8,495	16
17	TILING - REALTY			1998	635	17	39	17		238	17
18	BUILT IN CABINETRY - REALTY			1998	64,700	1,659	39	1,659		23,800	18
19	NEW COILS FOR AHV - REALTY			1999	6,000	154	39	154		2,081	19
20	NEW BOILER - REALTY			1999	20,328	521	39	521		7,040	20
21	HOT WATER TANK - REALTY			1999	2,750	71	39	71		959	21
22	ROOF - REALTY			1999	29,500	756	39	756		10,215	22
23	PATIO - REALTY			1999	5,080	339	15	339		4,579	23
24	AWNING - REALTY			1999	3,000	200	15	200		2,703	24
25	LIGHTS - REALTY			1999	7,603	195	39	195		2,635	25
26	NURSE CALL STATION - REALTY			1999	1,957	50	39	50		676	26
27	WINDOW TREATMENTS - REALTY			1999	11,207	287	39	287		3,879	27
28	CORRIDOR BORDERS - REALTY			1999	6,154	158	39	158		2,135	28
29	SCREENS - REALTY			2000	3,543	129	27.5	129		1,615	29
30	AIR CONDITIONER REPLACEMENT - REALTY			2001	14,540	529	27.5	529		6,089	30
31	DOOR DETECTOR - REALTY			2001	1,800	65	27.5	65		749	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY			2001	22,621	823	27.5	823		9,475	32
33	ROOF VENTILATORS - REALTY			2001	6,898	251	27.5	251		2,890	33
34	BOILER - REALTY			2001	63,746	2,318	27.5	2,318		26,686	34
35	WALK IN FREEZER - REALTY			2001	3,750	136	27.5	136		1,566	35
36	DOOR - REALTY			2001	2,970	108	27.5	108		1,243	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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
37	DRYER EXHAUST FAN - REALTY	2001	$ 4,050	$ 147	27.5	$ 147	$	$ 1,693	37
38	DOORS - REALTY	2001	1,995	72	27.5	72		829	38
39	DOORS - REALTY	2001	1,723	63	27.5	63		725	39
40	FLOOR TILING & CARPETING	2001	4,497		5			4,497	40
41	DRAPERIES	2001	12,722		5			12,722	41
42	HOT WATER HEATER & PIPING - REALTY	2002	19,857	722	27.5	722		7,590	42
43	ROOF - REALTY	2002	6,150	224	27.5	224		2,354	43
44	ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		884	44
45	DOORS - REALTY	2002	10,098	367	27.5	367		3,858	45
46	TILING - REALTY	2002	17,815	648	27.5	648		6,812	46
47	SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		2,239	47
48	ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		15,159	48
49	BOILER - REALTY	2002	9,550	347	27.5	347		3,648	49
50	ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		34,995	50
51	PATIO DOORS - REALTY	2003	2,300	84	27.5	84		803	51
52	FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		401	52
53	NURSES STATION - REALTY	2003	6,806	247	27.5	247		2,363	53
54	KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		986	54
55	KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		928	55
56	PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		1,626	56
57	COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		286	57
58	HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		2,975	58
59	LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		488	59
60	KICKPLATES - REALTY	2003	5,300	193	27.5	193		1,845	60
61	FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		286	61
62	DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		957	62
63	NEW FLOORING	2004	39,141	1,423	27.5	1,423		12,155	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		4,621	64
65	TILE FLOORING	2004	4,031	147	27.5	147		1,255	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		1,554	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		22,627	67
68	AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		1,700	68
69	POWER ROOF EXHAUST UNITS	2005	3,972	145	27.5	145		1,045	69
70	TOTAL (lines 4 thru 69)		$ 13,695,004	$ 356,909		$ 356,909	$	$ 5,156,758	70

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 13,695,004	$ 356,909		$ 356,909	$	$ 5,156,758	1
2	RECLAIM PUMPS	2005	1,770	64	27.5	64		462	2
3	POWER ROOF EXHAUST FANS	2005	3,545	129	27.5	129		930	3
4	GREASE BASIN	2005	11,800	429	27.5	429		3,092	4
5	CUBICAL CURTAINS	2005	3,784		5	(379)	(379)	3,784	5
6	WALL MOUNTED WATER COOLER	2006	1,808	66	27.5	66		420	6
7	FIRE SUPPRESSION SYSTEM	2006	5,200	189	27.5	189		1,206	7
8	DOORS	2006	2,150	78	27.5	78		543	8
9	CARPETING	2006	2,690		5	(319)	(319)	3,009	9
10	ROOF REPAIR - REALTY	2007	4,900	178	27.5	178		897	10
11	BUILDING IMPROVEMENT- REALTY	2006	41,151	1,496	27.5	1,496		9,475	11
12	BUILDING IMPROVEMENT	2007	(41,151)	(1,496)	27.5	(1,496)		(7,418)	12
13	BOILER- REALTY	2008	24,300	884	27.5	884		4,420	13
14	SPRINKLERS- REALTY	2008	12,879	468	27.5	468		2,145	14
15	ROOF TOP VENTILATOR	2010	5,345	194	27.5	194		542	15
16	NURSE CALL PANEL ANNUNCIATOR	2010	2,354	86	27.5	86		240	16
17	FURNISH AND INSTALL DOORS-"B" FIRE LABEL	2010	5,102	186	27.5	186		488	17
18	ROOFTOP CHILLER AND CRANKCASE HEATER	2010	11,350	413	27.5	413		1,084	18
19	NURSE CALL PANEL ANNUNCIATOR	2010	17,440	634	27.5	634		1,459	19
20	ROOFTOP EXHAUST	2010	13,183	479	27.5	479		1,178	20
21	FIX ROOF TOPS	2010	2,724	99	27.5	99		235	21
22	BOOSTER HEATER, UNITAIRE FAN COIL UNIT	2010	4,530	165	27.5	165		399	22
23	DURO-LAST ROOF SYSTEM	2010	90,500	3,291	27.5	3,291		6,993	23
24	REPLACEMENT OF THE BOILERS	2010	19,310	702	27.5	702		1,550	24
25	INSTALL FIRE ALARM PANEL	2010	7,746	282	27.5	282		576	25
26	SEC 754 BASIS ADJUSTMENT	2010		14,109			(14,109)		26
27	FIRE DOOR	2011	3,420	124	27.5	124		160	27
28	A/C REPAIR	2011	6,603	240	27.5	240		330	28
29	WINDOWS & DOORS	2011	4,050	147	27.5	147		190	29
30	FIRE WALLS,NURSES STATION -SINKS	2011	8,330	303	27.5	303		366	30
31	CABINETS	2011	12,089	440	27.5	440		532	31
32	AUDIO DEVICE	2011	2,870	104	27.5	104		204	32
33	CANOPY F E MORAN	2011	5,220	190	27.5	190		372	33
34	TOTAL (lines 1 thru 33)		$ 13,991,996	$ 381,582		$ 366,775	$ (14,807)	$ 5,196,621	34

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 12B, Carried Forward		$ 13,991,996	$ 381,582		$ 366,775	$ (14,807)	$ 5,196,621	1
2	TUCKPOINTING	2011	15,900	578	27.5	578		987	2
3	HVAC WALL UNITS	2011	5,000	182	27.5	182		326	3
4	FLOOR REPLACEMENT	2011	24,000	873	27.5	873		1,491	4
5	BOILER	2011	21,555	784	27.5	784		1,535	5
6	CHILLER	2011	59,700	2,171	27.5	2,171		1,538	6
7	FOOD PROCESSOR	2011	1,080	39	27.5	39		63	7
8	1ST FLOOR COLLING PIPE INSULATION	2012	8,740	278	27.5	278		278	8
9	SPRINKLER SYSTEM	2012	29,980	500	27.5	500		500	9
10	WINDOWS	2012	4,110	56	27.5	56		56	10
11	FIRE PANEL AND WIRING	2012	3,060	32	27.5	32		32	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)		$ 14,165,121	$ 387,075		$ 372,268	$ (14,807)	$ 5,203,427	34

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 178,048	$ (124)	$ 17,804	$ 17,928	10 YRS	$ 159,004	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,497,895					1,497,895	73
74	RELATED PARTY	134,163	25,314	25,314				74
75	TOTALS	$ 1,810,106	$ 25,190	$ 43,118	$ 17,928		$ 1,656,899	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)	$ 17,475,227	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 412,265	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,386	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,121	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,860,326	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED POARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 21,891 Description: SEE SCHEDULE ATTACHED
    (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	SEE ATTACHED SCHEDULE			59,685	18
19					19
20					20
21	TOTAL		$	$ 59,685	21

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

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 296,316	$		$ 296,316	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,473			10,473	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			299,244			299,244	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				381,466		381,466	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): LABORATORY					15,300			15,300	13
14	TOTAL			$		$ 621,333	$ 381,466		$ 1,002,799	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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 1,172,709	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,020,000))	4,771,869		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	165,572		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	214,920		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,325,070	$	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	133,540		15
16	Equipment, at Historical Cost	1,699,636		16
17	Accumulated Depreciation (book methods)	(1,747,196)		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 (spe SEC 754 BASIS ADJ	359,184		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 445,164	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,770,234	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,140,303	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,814,817		29
30	Accrued Salaries Payable	331,668		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,144		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,344,932	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	930,503		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)**	$ 930,503	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,275,435	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,494,799	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,770,234	$	48

***(See instructions.)**

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,430,916	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,430,916	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,424,383	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	(2,360,500)	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)**	$ (936,117)	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)**	$ 1,494,799	24	*

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,097,723	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,097,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,108	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 79,108	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***	56	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL INCOME	468,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 468,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,644,887	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,842,246	31
32	Health Care	5,055,091	32
33	General Administration	3,586,848	33
	B. Capital Expense		
34	Ownership	2,687,409	34
	C. Ancillary Expense		
35	Special Cost Centers	1,002,799	35
36	Provider Participation Fee	1,053,124	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(7,013)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,220,504	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,424,383	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,424,383	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,917,342	44
45	Private Pay - Net Inpatient Revenue	3,451	45
46	Medicare - Net Inpatient Revenue	4,099,667	46
47	Other-(specify) INSURANCE	77,263	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,097,723	49

****TAX RETURN PREPARED ON CASH BASIS**

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

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

*** **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 OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	2,091	$ 90,496	$ 43.28	1
2	Assistant Director of Nursing	2,083	2,099	70,654	33.66	2
3	Registered Nurses	13,213	13,952	421,402	30.20	3
4	Licensed Practical Nurses	62,854	63,858	1,494,551	23.40	4
5	CNAs & Orderlies	145,971	160,102	1,715,112	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,474	11,428	169,541	14.84	8
9	Activity Director					9
10	Activity Assistants	13,889	15,349	152,264	9.92	10
11	Social Service Workers	19,851	21,526	286,828	13.32	11
12	Dietician					12
13	Food Service Supervisor	2,010	2,177	49,089	22.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,855	39,849	389,307	9.77	15
16	Dishwashers					16
17	Maintenance Workers	12,936	13,492	175,039	12.97	17
18	Housekeepers	48,834	53,174	543,124	10.21	18
19	Laundry	12,510	13,595	125,748	9.25	19
20	Administrator	3,900	3,900	134,069	34.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,494	14,135	234,928	16.62	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	1,827	1,996	28,125	14.09	31
32	Other Health C: See Attached	16,213	17,449	319,001	18.28	32
33	Other(specify) Security & Transp	25,906	27,774	269,168	9.69	33
34	TOTAL (lines 1 - 33)	443,831	477,946	$ 6,668,446 *	$ 13.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 16,649	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	14,832	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		38,860	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,285	11-3	44
45	Social Service Consultant	E	4,929	12-3	45
46	Other(specify) DENTAL	S	3,900	10-3	46
47	PHYSICIANS		500	10-3	47
48	Occupational Therapy Consultant		332	10a-3	48
49	TOTAL (lines 35 - 48)		$ 89,287		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED BERKOVITS	ADMINISTRATOR		$ 57,500
NANCY GIVEN	ADMINISTRATOR		76,569
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,069

B. Administrative - Other

Description	Amount
EMI ENTERPRISES MANAGEMENT	$ 871,000
BRIA HEALTH SERVICES INC	80,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 951,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		180,785
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 180,785

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 187,565
Unemployment Compensation Insurance	198,028
FICA Taxes	504,434
Employee Health Insurance	295,136
Employee Meals	12,298
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,675
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	70,127
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,271,263

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	4,530
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	7,674
MARKETING/ADV/PROMO	4,300
LICENSES/DUES/SUBSCRIPTIONS	12,374
MGMT CO ALLOC	5,787
TRUST/FRANCHISE/CONTRIB/ETC	(7,674)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,300)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,691

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number RIVER OAKS HEALTHCARE REHAB CENTER # 0052043 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. **IL COUNCIL LONG TERM CARE $ 5,562**

(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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
BURNHAM HEALTHCARE PROPERTIES,LLC #0043398 11/1/12

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ ########
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. $ **12,298** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
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? **NO**
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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.