FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052761

Facility Name: River Crossing Rehab

Address: 1145 Frank Street (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 342-2103 **Fax #** (309) 342-1819

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2013

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: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

III. STATISTICAL DATA

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

	1 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	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	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	4,213	308	1,465	5,986	8
9	SNF/PED					9
10	ICF	18,704	35	2,437	21,176	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,917	343	3,902	27,162	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.90%

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 [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 11/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 962

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	136,321	19,625	15,487	171,433		171,433	7,702	179,135			1
2	Food Purchase		141,325		141,325		141,325	(1,400)	139,925			2
3	Housekeeping	99,089	24,745		123,834		123,834		123,834			3
4	Laundry	55,083	11,363	20	66,466		66,466		66,466			4
5	Heat and Other Utilities			101,075	101,075		101,075	(6,966)	94,109			5
6	Maintenance	42,695	14,540	43,931	101,166		101,166	8,590	109,756			6
7	Other (specify):*							1,636	1,636			7
8	**TOTAL General Services**	333,188	211,598	160,513	705,299		705,299	9,562	714,861			8
	B. Health Care and Programs											
9	Medical Director			18,262	18,262		18,262		18,262			9
10	Nursing and Medical Records	1,111,941	233,419	39,844	1,385,204		1,385,204	(2,142)	1,383,062			10
10a	Therapy	163,647	1,684	258	165,589		165,589		165,589			10a
11	Activities	37,808	1,742	576	40,126		40,126		40,126			11
12	Social Services	118,448		5,040	123,488		123,488		123,488			12
13	CNA Training											13
14	Program Transportation			955	955		955	2,024	2,979			14
15	Other (specify):*							2,680	2,680			15
16	**TOTAL Health Care and Programs**	1,431,844	236,845	64,935	1,733,624		1,733,624	2,562	1,736,186			16
	C. General Administration											
17	Administrative	66,834		135,378	202,212		202,212	(91,011)	111,201			17
18	Directors Fees											18
19	Professional Services			308,405	308,405	(184)	308,221	(213,965)	94,256			19
20	Dues, Fees, Subscriptions & Promotions			87,029	87,029		87,029	(33,725)	53,304			20
21	Clerical & General Office Expenses	38,647		233,755	272,402		272,402	(129,629)	142,773			21
22	Employee Benefits & Payroll Taxes			281,744	281,744		281,744		281,744			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,395	3,395		3,395	1,096	4,491			24
25	Other Admin. Staff Transportation			8,959	8,959		8,959	3,701	12,660			25
26	Insurance-Prop.Liab.Malpractice			119,314	119,314		119,314	4,501	123,815			26
27	Other (specify):*							10,573	10,573			27
28	**TOTAL General Administration**	105,481		1,177,979	1,283,460	(184)	1,283,276	(448,459)	834,817			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,870,513	448,443	1,403,427	3,722,383	(184)	3,722,199	(436,335)	3,285,864			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 Crossing Rehab #0052761 Report Period Beginning: Ending: 12/31/14

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			17,126	17,126		17,126	9,491	26,617			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,432	2,432		2,432	(148)	2,284			32
33	Real Estate Taxes			21,840	21,840	184	22,024	1,537	23,561			33
34	Rent-Facility & Grounds			256,046	256,046		256,046	(16,694)	239,352			34
35	Rent-Equipment & Vehicles			4,105	4,105		4,105	3,647	7,752			35
36	Other (specify):*			770	770		770	(770)				36
37	**TOTAL Ownership**			302,319	302,319	184	302,503	(2,937)	299,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,488	358,385	359,873		359,873		359,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			216,403	216,403		216,403		216,403			42
43	Other (specify):*			81,346	81,346		81,346	(81,346)				43
44	**TOTAL Special Cost Centers**		1,488	656,134	657,622		657,622	(81,346)	576,276			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,870,513	449,931	2,361,880	4,682,324		4,682,324	(520,618)	4,161,706			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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	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	(1,382)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,419)	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	6,845	30		9
10	Interest and Other Investment Income	(2,044)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	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	(44,051)	21		18
19	Entertainment	(3,257)	21		19
20	Contributions	(33,267)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128,451)	21		24
25	Fund Raising, Advertising and Promotional	(19,866)	43		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	(168,441)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (401,351)		$	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)	(119,267)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (119,267)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (520,618)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

River Crossing Rehab

ID# **0052761**

Report Period Beginning:

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (10,174)	21	1
2	Theft and Damage Loss	(102)	21	2
3	Amortization	(770)	36	3
4	Non Allowable Fees	(61,480)	43	4
5	Additional R&M	6,785	06	5
6	Non Allowable Legal	(38,782)	19	6
7	Non Allowable Professional Fee	(49,774)	19	7
8	PAC Dues	(1,635)	20	8
9	Non Allowable Dues	(300)	20	9
10	Capitalized R&M	(5,956)	06	10
11	Non Allowable Rent	(5,000)	34	11
12	Website Expense	(1,253)	21	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**	(168,441)		49

River Crossing Rehab

ID# 0052761

Report Period Beginning:

Ending: 12/31/14

	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Crossing Rehab # 0052761 **Report Period Beginning:** **Ending:** 12/31/14

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					3,770	116	3,816					7,702	1
2	Food Purchase	(1,400)											(1,400)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,419)					220		233				(6,966)	5
6	Maintenance	829		1,873		1,551	1,904	2,155	278				8,590	6
7	Other (specify):*			123		773	377	363					1,636	7
8	**TOTAL General Services**	(7,990)		1,996		6,094	2,617	6,334	511				9,562	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			1,623		3,048		(6,813)					(2,142)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							2,024					2,024	14
15	Other (specify):*			121		1,579		980					2,680	15
16	**TOTAL Health Care and Programs**			1,744		4,627		(3,809)					2,562	16
	C. General Administration													
17	Administrative			(106,550)	1,105		6,863	7,571					(91,011)	17
18	Directors Fees													18
19	Professional Services	(88,556)		(33,390)	(27,932)	54	(59,761)	(2,260)	473	(2,593)			(213,965)	19
20	Fees, Subscriptions & Promotions	(35,202)		1,144	16	5	278	12	22				(33,725)	20
21	Clerical & General Office Expenses	(187,288)		12,449	15,322	664	22,705	5,928	591				(129,629)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			509	9	150	122	306					1,096	24
25	Other Admin. Staff Transportation			1,444	16	1,132	831	278					3,701	25
26	Insurance-Prop.Liab.Malpractice			382	3,198		861	60					4,501	26
27	Other (specify):*			2,429		78	7,263	803					10,573	27
28	**TOTAL General Administration**	(311,046)		(121,583)	(8,266)	2,083	(20,838)	12,698	1,086	(2,593)			(448,459)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(319,036)		(117,843)	(8,266)	12,804	(18,221)	15,223	1,597	(2,593)			(436,335)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Crossing Rehab **#** 0052761 **Report Period Beginning:** **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	6,845				7	714		1,925				9,491	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,044)					326		1,570				(148)	32
33	Real Estate Taxes								1,537				1,537	33
34	Rent-Facility & Grounds	(5,000)		526			(355)		(11,865)				(16,694)	34
35	Rent-Equipment & Vehicles			1,283	82	410	574	1,074	224				3,647	35
36	Other (specify):*	(770)											(770)	36
37	**TOTAL Ownership**	(969)		1,809	82	417	1,259	1,074	(6,609)				(2,937)	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):*	(81,346)											(81,346)	43
44	**TOTAL Special Cost Centers**	(81,346)											(81,346)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(401,351)		(116,034)	(8,184)	13,221	(16,962)	16,297	(5,012)	(2,593)			(520,618)	45

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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 [X] 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			$			$	$	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.**

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	6	REPAIRS & MAINTENANCE		APERION CARE	100.00%	1,873	$ 1,873	15
16	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	123	123	16
17	V	10	SALARY- NURSE		APERION CARE	100.00%	1,623	1,623	17
18	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	121	121	18
19	V	17	ADMINISTRATIVE		APERION CARE	100.00%	23,089	23,089	19
20	V	19	PROFESSIONAL FEES		APERION CARE	100.00%	2,401	2,401	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,144	1,144	21
22	V	21	CLERICAL & GENERAL		APERION CARE	100.00%	12,449	12,449	22
23	V	24	SEMINARS		APERION CARE	100.00%	509	509	23
24	V	25	AUTO AND TRAVEL		APERION CARE	100.00%	1,444	1,444	24
25	V	26	INSURANCE		APERION CARE	100.00%	382	382	25
26	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	2,429	2,429	26
27	V	34	RENT		APERION CARE	100.00%	526	526	27
28	V	35	EQUIPMENT RENTAL		APERION CARE	100.00%	17	17	28
29	V	35	AUTO LEASE		APERION CARE	100.00%	1,266	1,266	29
30	V	17	MANAGEMENT FEE	129,639	APERION CARE	100.00%		(129,639)	30
31	V	19	HOME OFFICE	34,713	APERION CARE	100.00%		(34,713)	31
32	V	19	DATA PROCESSING	1,078	APERION CARE	100.00%		(1,078)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 165,430			$ 49,396	$ * (116,034)	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	ADMINISTRATIVE		APERION FINANCIAL	100.00%	1,105	$ 1,105	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL	100.00%	449	449	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	16	16	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL	100.00%	15,322	15,322	18
19	V	24	SEMINARS		APERION FINANCIAL	100.00%	9	9	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL	100.00%	16	16	20
21	V	26	INSURANCE		APERION FINANCIAL	100.00%	3,198	3,198	21
22	V	35	EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	82	82	22
23	V	19	HOME OFFICE EXPENSE	28,381	APERION FINANCIAL	100.00%		(28,381)	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			$ 28,381			$ 20,197	$ * (8,184)	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	1	DIETARY	$	APERION CONSULTING	100.00%	$ 3,770	$ 3,770	15
16	V	5	UTILITIES		APERION CONSULTING	100.00%			16
17	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	1,551	1,551	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	773	773	18
19	V	10	SALARY NURSE		APERION CONSULTING	100.00%	10,860	10,860	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	1,579	1,579	20
21	V	17	ADMINISTRATIVE		APERION CONSULTING	100.00%			21
22	V	19	PROFESSIONAL FEES		APERION CONSULTING	100.00%	54	54	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	5	5	23
24	V	21	CLERICAL & GENERAL		APERION CONSULTING	100.00%	664	664	24
25	V	24	SEMINARS		APERION CONSULTING	100.00%	150	150	25
26	V	25	AUTO AND TRAVEL		APERION CONSULTING	100.00%	1,132	1,132	26
27	V	26	INSURANCE		APERION CONSULTING	100.00%			27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	78	78	28
29	V	30	DEPRECIATION		APERION CONSULTING	100.00%	7	7	29
30	V	35	AUTO LEASE		APERION CONSULTING	100.00%	410	410	30
31	V	10	CONSULTING	7,812	APERION CONSULTING	100.00%		(7,812)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,812			$ 21,033	$ * 13,221	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	1	DIETARY	$	YAM MANAGEMENT, LLC	100.00%	$ 116	$ 116	15
16	V	5	UTILITIES		YAM MANAGEMENT, LLC	100.00%	220	220	16
17	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,904	1,904	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		YAM MANAGEMENT, LLC	100.00%	377	377	18
19	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	6,863	6,863	19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,185	2,185	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	278	278	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	36,787	36,787	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	122	122	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	831	831	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	861	861	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,263	7,263	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	714	714	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	326	326	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%			29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	4,456	4,456	30
31	V	34	PARKING RENTAL		YAM MANAGEMENT, LLC	100.00%	189	189	31
32	V	35	AUTO LEASE		YAM MANAGEMENT, LLC	100.00%	574	574	32
33	V								33
34	V	19	ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	34
35	V	19	DATA PROCESSING	6,453	YAM MANAGEMENT, LLC	100.00%		(6,453)	35
36	V	19	BOOKKEEPING	43,493	YAM MANAGEMENT, LLC	100.00%		(43,493)	36
37	V	21	CORPORATE EVENTS	14,082	YAM MANAGEMENT, LLC	100.00%		(14,082)	37
38	V	34	RENT	5,000	YAM MANAGEMENT, LLC	100.00%		(5,000)	38
39	Total			$ 81,028			$ 64,066	$ * (16,962)	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 3,816	$ 3,816	15
16	V	5	UTILITIES		YAM CONSULTING, LLC	100.00%			16
17	V	6	REPAIRS & MAINTENANCE		YAM CONSULTING, LLC	100.00%	2,155	2,155	17
18	V	7	EMP. BEN.-GEN. SERV.		YAM CONSULTING, LLC	100.00%	363	363	18
19	V	10	NURSE SALARY		YAM CONSULTING, LLC	100.00%	16,137	16,137	19
20	V	15	EMP. BEN.-NURSE		YAM CONSULTING, LLC	100.00%	980	980	20
21	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	7,571	7,571	21
22	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	2,240	2,240	22
23	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	12	12	23
24	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	5,928	5,928	24
25	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	306	306	25
26	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	278	278	26
27	V	26	INSURANCE		YAM CONSULTING, LLC	100.00%	60	60	27
28	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	803	803	28
29	V	14	NURSE TRAVEL		YAM CONSULTING, LLC	100.00%	2,024	2,024	29
30	V	32	INTEREST		YAM CONSULTING, LLC	100.00%			30
31	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	1,074	1,074	31
32	V	10	NURSE CONSULTING	22,950	YAM CONSULTING, LLC	100.00%		(22,950)	32
33	V	19	DATA PROCESSING	4,500	YAM CONSULTING, LLC	100.00%		(4,500)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,450			$ 43,747	$ * 16,297	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	5	UTILITIES	$	8131 N. MONTICELLO, LLC	100.00%	$ 233	$ 233	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	278	278	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	473	473	17
18	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	22	22	18
19	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	591	591	19
20	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,925	1,925	20
21	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,570	1,570	21
22	V	34	RENT		8131 N. MONTICELLO, LLC	100.00%	306	306	22
23	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	224	224	23
24	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,537	1,537	24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC	100.00%		(7,000)	26
27	V	34	RENT	5,171	8131 N. MONTICELLO, LLC	100.00%		(5,171)	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			$ 12,171			$ 7,159	$ * (5,012)	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	19	Payroll Services	$ 12,350	ProPay HR	24.00%	$ 9,757	$ (2,593)	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			$ 12,350			$ 9,757	$ * (2,593)	39

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YOSEF MEYSTEL TRUST	18.50%	Aperion Care Amboy	Amboy	YAM MANAGEMENT (1/1/14-6/3	SKOKIE	MANAGEMENT CO.	1
2	DAVID BERKOWITZ TRUST	24.50%	Aperion Care Jacksonville	Jacksonville	YAM CONSULTING (1/1/14-6/30/1	SKOKIE	CONSULTING CO.	2
3	MICHAEL ROSEN	29.50%	Aperion Care Forest Park	Forest Park	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	42170 LTD PARTNERSHIP	2.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	257 LTD PARTNERSHIP	2.00%	Riverwood Rehab	East Moline	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	FREDRICK S. FRANKEL	1.00%	Apetion Care Bridgeport	Bridgeport	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	STEVEN TUROFSKY	1.00%	Aperion Care Litchfield	Litchfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	MORRIS ESFORMES	3.00%	Aperion Care Springfield	Springfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	DELECIA ESFORMES	3.00%	Aperion Care Evanston	Evanston	APERION ESTATES PERU	PERU, IN	ALF	9
10	SYLVIA YOLINSKY	3.00%	Aperion Care Midlothian	Midlothian	APERION CARE COPPERAS HO	CALDWELL, TX	ALF	10
11	JACK AND MARY YOLINSKY	3.00%	Aperion Care St. Elmo	St. Elmo	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	11
12	MGB MININ DEF BENEFIT PENSION UA 1/1/08	3.00%	Aperion Care Chicago Heights	Chicago Heights				12
13	DAVID WIRTENBERG AND SCOTT MESNICK		Aperion Care Dolton	Dolton				13
14	HOWARD BORENSTEIN	4.50%	Aperion Care Oak Lawn	Oak Lawn				14
15	1219 LTD PARTNERSHIP	2.00%	Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Arbors Michigan City	Michigan City, IN				20
21			Aperion Care Demotte	Demotte,IN				21
22			Aperion Care Kokomo	Kokomo, IN				22
23			Aperion Care Peru	Peru, IN				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Valparaiso	Valparaiso, IN				25
26			Aperion Care Copperas Hollow	Caldwell, TX				26
27								27
28								28
29								29
30								30

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.3	3.25%	Alloc. Salary	$ 5,557	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	1,059	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	1,361	17-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	697	21-7	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.3	3.25%	Alloc. Salary	1,280	21-7	5
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.3	3.25%	Alloc. Salary	5,557	17-7	6
7	Fredrick Frankel	Owner	Administrative	1.50%	See Attached	1.3	3.25%	Alloc. Salary	4,580	17-7	7
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	1.3	3.25%	Alloc. Salary	5,007	17-7	8
9	Michael Rosen	Owner	Administrative	29.50%	See Attached	1.3	3.25%	Alloc. Salary	8,275	17-7/17-3	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	$ 33,373		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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: APERION CARE
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	67,680	59,564	11,950	1,873	1
2	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	4,451		11,950	123	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	11,950	1,623	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381		11,950	121	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	11,950	23,089	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759		11,950	2,401	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339		11,950	1,144	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	11,950	12,449	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383		11,950	509	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156		11,950	1,444	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783		11,950	382	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772		11,950	2,429	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000		11,950	526	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601		11,950	17	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731		11,950	1,266	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,587	$ 1,312,845		$ 49,396	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: APERION FINANCIAL
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	39,916		11,950	1,105	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	16,216		11,950	449	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	570		11,950	16	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	553,558	596,633	11,950	15,322	4
5	24	SEMINARS	ACTUAL CENSUS	431,728	30	342		11,950	9	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	585		11,950	16	6
7	26	INSURANCE	ACTUAL CENSUS	431,728	30	115,531		11,950	3,198	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	2,974		11,950	82	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					$ 729,692	$ 596,633		$ 20,197	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: APERION CONSULTING
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	ACTUAL CENSUS	431,728	30	$ 136,198	$ 136,198	11,950	$ 3,770	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30			11,950		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	11,950	1,551	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		11,950	773	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	11,950	10,860	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		11,950	1,579	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			11,950		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		11,950	54	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		11,950	5	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	11,950	664	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		11,950	150	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		11,950	1,132	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			11,950		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		11,950	78	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		11,950	7	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		11,950	410	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 759,903	$ 603,946		$ 21,033	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: YAM MANAGEMENT, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	ACTUAL CENSUS	375,486	26	$ 2,866	$ 2,866	15,212	$ 116	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432		15,212	220	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	15,212	1,904	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302		15,212	377	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	15,212	6,863	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925		15,212	2,185	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855		15,212	278	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	15,212	36,787	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004		15,212	122	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508		15,212	831	10
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257		15,212	861	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286		15,212	7,263	12
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623		15,212	714	13
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053		15,212	326	14
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26			15,212		15
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000		15,212	4,456	16
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655		15,212	189	17
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167		15,212	574	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,581,370	$ 845,178		$ 64,066	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: YAM CONSULTING, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	ACTUAL CENSUS	375,486	26	$ 94,203	$ 94,203	15,212	$ 3,816	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26			15,212		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	15,212	2,155	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		15,212	363	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	15,212	16,137	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		15,212	980	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	15,212	7,571	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		15,212	2,240	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		15,212	12	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	15,212	5,928	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		15,212	306	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		15,212	278	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		15,212	60	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		15,212	803	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		15,212	2,024	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		15,212		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		15,212	1,074	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,079,857	$ 872,186		$ 43,747	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 8131 N. MONTICELLO, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	ACTUAL CENSUS	807,214	30	$ 6,925	$	27,162	$ 233	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268		27,162	278	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051		27,162	473	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646		27,162	22	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570		27,162	591	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207		27,162	1,925	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653		27,162	1,570	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100		27,162	306	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667		27,162	224	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673		27,162	1,537	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					$ 212,760	$		$ 7,159	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 9,757	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					$	$		$ 9,757	25

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				509,239	12/11/15	3.6450	877	6
7	Auto Loan		X					39,858				7
8	See Supplemental Schedule										1,554	8
9	TOTAL Facility Related						$	$ 549,097			$ 2,431	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,044)	10
11	Allocated from 8131 N. Monticello										1,570	11
12	Allocated from YAM Management										326	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (148)	14
15	TOTALS (line 9+line14)						$	$ 549,097			$ 2,283	15

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

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

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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

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

	1	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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Insurance Policies						$	$			$ 1,554	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,554	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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.)

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,379	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.)		$ 26,277	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,102)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,478	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.)**		$ 184	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.		$ 23,560	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	63,143	8
	2010	38,411	9
	2011	38,955	10
	2012	23,782	11
	2013	24,740	12

Beginning Accrual ADJ
2014 Accrual = 1.05% X $24,740
Allocated from 8131 N. Monticello- $1,537

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Crossing Rehab COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-09-202-017	Long Term Care Facility	$ 24,740.06	$ 24,740.06
2.	10-23-325-045-0000	Home Office Allocation	$ 64,433.32	$ 1,899.25
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 89,173.38	$ 26,639.31

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? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Crossing Rehab COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ **B.** General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [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	Allocated from 8131 N. Monticello			$ 2,995	1
2					2
3	TOTALS			$ 2,995	3

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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					$	$		$	$	$	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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			$	$		$	$	$	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		37,095	2,634		1,348	(1,286)	5,713	68
69	Financial Statement Depreciation			17,126			(17,126)		69
70	TOTAL (lines 4 thru 69)		$ 37,095	$ 19,760		$ 1,348	$ (18,412)	$ 5,713	70

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 37,095	$ 19,760		$ 1,348	$ (18,412)	$ 5,713	1
2	Fire Sprinklers	2013	68,730		20	3,437	3,437	6,014	2
3	New White Alucabond Face Panel Mounted Sign	2014	4,141		20	138	138	138	3
4	Entrance Sign And 2 Formed Pan Faces	2014	5,450		20	1,090	1,090	1,090	4
5	Ao Smith 100 Gallon Natural Gas Water Heater	2014	8,740		20	874	874	874	5
6	Security Camera System Installation	2014	13,842		20	1,154	1,154	1,154	6
7	Drain, Remove & Replace Old 100 Gal Gas Tank	2014	5,168		20	108	108	108	7
8	New Landscape Design	2014	9,494		20	316	316	316	8
9	Vestibule:New Ceramic Tile & Walk Off Carpet Tile: Dumpster	2014	14,132		20	707	707	707	9
10	Lounge/Dining Room:New Vinyl Plankwood Tile, Wallcovering	2014	35,072		20	1,754	1,754	1,754	10
11	Admissions Office & Activity Room: New Carpet Tile, Wallcoverin	2014	4,620		20	231	231	231	11
12	Conference Room: New Carpet Tile, Wallcovering	2014	4,498		20	225	225	225	12
13	Therapy Room:Replace Carpet With Vinyl Tile, Wallcovering	2014	10,288		20	514	514	514	13
14	2 North Corridors: New Premium Vct And Pure Vinyl Tile	2014	10,864		20	543	543	543	14
15	2 South Corridors: New Premium Vct And Pure Vinyl Tile	2014	7,917		20	396	396	396	15
16	Corridors: Wallcovering, Handrails, Bumper Guards, Corner Gua	2014	34,495		20	1,725	1,725	1,725	16
17	Nurse Call System Annunicaitor Panel	2014	5,956		20	298	298	298	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)		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	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)		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12C, Carried Forward		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	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)		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12D, Carried Forward		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	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)		$ 280,503	$ 19,760		$ 14,857	$ (4,903)	$ 21,799	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12F, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	23,269	692	35	597	(95)	2,660	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from 8131 N. Monticello	2010	10,423	1,047	20	521	(526)	2,365	9
10	Allocated from 8131 N. Monticello	2013	1,813	181	20	91	(90)	181	10
11	Allocated from YAM Management			714			(714)		11
12	Allocated from Aperion Care	2010	912		20	91	91	390	12
13	Allocated from Aperion Care	2012	576		20	38	38	97	13
14	Allocated from Aperion Care	2013	102		20	10	10	20	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)		$ 37,095	$ 2,634		$ 1,348	$ (1,286)	$ 5,713	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12H, Carried Forward		$ 37,095	$ 2,634		$ 1,348	$ (1,286)	$ 5,713	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)		$ 37,095	$ 2,634		$ 1,348	$ (1,286)	$ 5,713	34

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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	$ 7,653	$	$ 1,359	$ 1,359	10	$ 2,710	71
72	Current Year Purchases	27,681	12	3,206	3,194	10	3,206	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 35,334	$ 12	$ 4,565	$ 4,553		$ 5,916	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		2013 GMC SAVANA	2013	$ 54,662	$	$ 7,007	$ 7,007	5	$ 12,864	76
77		Allocated from Aperion Care	2014	941		188	188	5	661	77
78										78
79										79
80	TOTALS			$ 55,603	$	$ 7,195	$ 7,195		$ 13,525	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)	$ 374,435	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,772	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,617	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,845	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 41,240	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Kraus Home

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. [X] 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:	1972	108		$ 239,046			3
4	Additions							4
5	Allocated from 8131 N. Monticello				306			5
6								6
7	TOTAL		108		$ 239,352 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 4,428 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	Allocated from YAM Consulting		$	$ 1,074	17
18	Allocated from YAM Management			574	18
19	Allocated from Aperion Care			1,266	19
20	Allocated from Aperion Consulting			410	20
21	TOTAL		$	$ 3,324	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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 - 03	hrs	$		$ 175,436	$		$ 175,436	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			24,040			24,040	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			120,931			120,931	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			28,141			28,141	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					9,837	1,488		11,325	13
14	TOTAL			$		$ 358,385	$ 1,488		$ 359,873	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 676	$	1
2	Cash-Patient Deposits	20,159		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,011,732		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,444		6
7	Other Prepaid Expenses	778		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	50,242		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,152,031	$	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	182,190		15
16	Equipment, at Historical Cost	107,314		16
17	Accumulated Depreciation (book methods)	(23,106)		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):	646,167		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 912,565	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,064,596	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 472,666	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,223		28
29	Short-Term Notes Payable	549,097		29
30	Accrued Salaries Payable	89,895		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,095		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,478		32
33	Accrued Interest Payable	877		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	71,900		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,234,231	$	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	See Attached Schedule	898,108		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 898,108	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,132,339	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (67,743)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,064,596	$	48

***(See instructions.)**

Facility Name & ID Number River Crossing Rehab **#** 0052761 **Report Period Beginning:** **Ending:** 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 107,139	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 107,139	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(174,882)	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	( )	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)**	$ (174,882)	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)**	$ (67,743)	24	*

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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	$ 3,136,020	1
2	Discounts and Allowances for all Levels	1,162,680	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,298,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	181,557	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 181,557	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	1,382	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	20,179	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,256	19
20	Radiology and X-Ray	432	20
21	Other Medical Services	1,892	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25,141	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,044	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,044	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,507,442	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	705,299	31
32	Health Care	1,733,624	32
33	General Administration	1,283,460	33
	B. Capital Expense		
34	Ownership	302,319	34
	C. Ancillary Expense		
35	Special Cost Centers	441,219	35
36	Provider Participation Fee	216,403	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,682,324	40
41	**Income before Income Taxes (line 30 minus line 40)****	(174,882)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (174,882)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,346,906	44
45	Private Pay - Net Inpatient Revenue	27,415	45
46	Medicare - Net Inpatient Revenue	480,908	46
47	Other-(specify)	443,471	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,298,700	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 Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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	3,033	3,303	$ 93,297	$ 28.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,559	11,371	204,721	18.00	3
4	Licensed Practical Nurses	21,587	22,845	386,037	16.90	4
5	CNAs & Orderlies	41,448	42,960	402,016	9.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,254	8,129	163,647	20.13	8
9	Activity Director					9
10	Activity Assistants	4,343	4,506	37,808	8.39	10
11	Social Service Workers	6,843	6,961	118,448	17.02	11
12	Dietician					12
13	Food Service Supervisor	2,176	2,582	41,604	16.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,185	10,890	94,717	8.70	15
16	Dishwashers					16
17	Maintenance Workers	3,152	3,258	42,695	13.10	17
18	Housekeepers	10,415	11,284	99,089	8.78	18
19	Laundry	6,058	6,545	55,083	8.42	19
20	Administrator	2,000	2,159	66,834	30.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,920	2,080	38,647	18.58	23
24	Clerical					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	2,408	2,507	25,870	10.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,381	141,380	$ 1,870,513 *	$ 13.23	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	298	$ 15,487	01-03	35
36	Medical Director	Monthly	18,262	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	368	30,762	10-03	38
39	Pharmacist Consultant	Monthly	8,280	10-03	39
40	Physical Therapy Consultant	Various	258	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	576	11-03	44
45	Social Service Consultant	81	5,040	12-03	45
46	Other(specify) Psychiatric MD	12	802	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	774	$ 79,467		49

C. CONTRACT NURSES

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

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Leighty (5/7/13-4/8/14)	Administrator	0	$ 19,172
Laura Paxton (12/11/14-present)	Administrator	0	3,896
Michelle Young (4/9/14-12/10/14)	Administrator	0	43,766
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,834

B. Administrative - Other

Description	Amount
Michael Rosen- Management Fees	$ 5,739
Aperion Care- Management Fees	129,639
TOTAL (agree to Schedule V, line 17, col. 3)	$ 135,378
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aperion Care	Home Office Expense	$ 34,713
Aperion Financial	Home Office Expense	28,381
ProPay HR	Payroll Processing	12,350
Various	Legal	55,710
Pendulum, LLC	Risk Management services	1,603
Ability Network	Data Processing	915
Non Allowable Professional Fees	ADJ pg 5a	49,774
YAM Management	Bookkeeping	43,493
YAM Management	Accounting	12,000
YAM Consulting	Data Processing	4,500
Aperion Care	Data Processing	1,078
See Supplemental Schedule		63,888
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 308,405

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,232
Unemployment Compensation Insurance	52,948
FICA Taxes	133,888
Employee Health Insurance	18,236
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	240
Employee Benefits- Other	200
TOTAL (agree to Schedule V, line 22, col.8)	$ 281,744

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,472
Advertising: Employee Recruitment	29,039
Health Care Worker Background Check	7,350
(Indicate # of checks performed 349)	
Patient Background Checks	
Dues & Subscriptions	7,494
License & Permits	1,471
Allocated from YAM Consulting	12
Allocated from YAM Management	278
See Supplemental Schedule	1,187
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,303

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,395
Allocated from YAM Consulting	305
Allocated from YAM Management	122
See Supplemental Schedule	668
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,490

**See instructions.

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number River Crossing Rehab # 0052761 Report Period Beginning: Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC $4,956**

(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. $ **6,623** 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. $ **216,403**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,382**

(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% ln 14**
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? **N/A**
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? **N/A**

(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.