

		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.

<p>I. IDPH License ID Number: <u>0052563</u></p> <p>Facility Name: <u>River North of Bradley H & R</u></p> <p>Address: <u>650 North Kinzie</u> <u>Bradley</u> <u>60915</u> Number City Zip Code</p> <p>County: <u>Kankakee</u></p> <p>Telephone Number: <u>(815) 933-1666</u> Fax # <u>(815) 933-9866</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/1/2013</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td> </tr> <tr> <td colspan="2">(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																								
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																								
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input type="checkbox"/> "Sub-S" Corp.																																									
	<input checked="" type="checkbox"/> Limited Liability Co.																																									
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) _____																																									
	(Title) _____																																									
Paid Preparer	(Signed) _____	(Date) _____																																								
	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>																																									
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																																									
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																																									
<p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<p>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</p>																																									

Facility Name & ID Number River North of Bradley H & R

0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>67</u>	Skilled (SNF)	<u>67</u>	<u>24,455</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,345</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,211</u>	<u>233</u>	<u>4,852</u>	<u>6,296</u>	8
9	SNF/PED					9
10	ICF	<u>18,476</u>	<u>4,793</u>	<u>5,185</u>	<u>28,454</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,687</u>	<u>5,026</u>	<u>10,037</u>	<u>34,750</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.34%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 12/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 67 and days of care provided 4,569

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	14,509	2,098	230,902	247,509		247,509	(80)	247,429		1
2	Food Purchase		232,868		232,868	(9,329)	223,539	(335)	223,204		2
3	Housekeeping	14,538	3,808	159,751	178,097		178,097		178,097		3
4	Laundry	4,767	1,847	105,344	111,958		111,958		111,958		4
5	Heat and Other Utilities			138,238	138,238		138,238	(8,283)	129,955		5
6	Maintenance	46,458	30,478	37,075	114,011		114,011	26,386	140,397		6
7	Other (specify):*							734	734		7
8	TOTAL General Services	80,272	271,099	671,310	1,022,681	(9,329)	1,013,352	18,421	1,031,773		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	1,522,444	119,205	8,250	1,649,899		1,649,899	(63)	1,649,836		10
10a	Therapy	12,506			12,506		12,506		12,506		10a
11	Activities	102,151	2,997	3,059	108,207		108,207		108,207		11
12	Social Services	56,642			56,642		56,642		56,642		12
13	CNA Training										13
14	Program Transportation			633	633		633		633		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,693,743	122,202	18,542	1,834,487		1,834,487	(63)	1,834,424		16
	C. General Administration										
17	Administrative	205,631		17,000	222,631		222,631	85,647	308,278		17
18	Directors Fees										18
19	Professional Services			198,491	198,491	(388)	198,103	(132,023)	66,080		19
20	Dues, Fees, Subscriptions & Promotions			25,215	25,215		25,215	(6,559)	18,656		20
21	Clerical & General Office Expenses	60,877	3,143	257,130	321,150		321,150	(163,655)	157,495		21
22	Employee Benefits & Payroll Taxes			276,617	276,617	9,329	285,946		285,946		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,151	9,151		9,151	(522)	8,629		24
25	Other Admin. Staff Transportation			12,398	12,398		12,398	2,972	15,370		25
26	Insurance-Prop.Liab.Malpractice			116,255	116,255		116,255	(1,028)	115,227		26
27	Other (specify):*							23,002	23,002		27
28	TOTAL General Administration	266,508	3,143	912,257	1,181,908	8,941	1,190,849	(192,166)	998,684		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,040,523	396,444	1,602,109	4,039,076	(388)	4,038,688	(173,807)	3,864,881		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 North of Bradley H & R

#0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			97,124	97,124		97,124	(74,409)	22,715			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,129	12,129		12,129	1,522	13,651			32
33	Real Estate Taxes			72,000	72,000	388	72,388	3,101	75,489			33
34	Rent-Facility & Grounds			615,900	615,900		615,900		615,900			34
35	Rent-Equipment & Vehicles			21,138	21,138		21,138	8,371	29,509			35
36	Other (specify):*											36
37	TOTAL Ownership			818,291	818,291	388	818,679	(61,415)	757,264			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,425	184,219	662,051	847,695		847,695	(1,281)	846,414			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,778	252,778		252,778		252,778			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	1,425	184,219	914,829	1,100,473		1,100,473	(1,281)	1,099,192			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,041,948	580,663	3,335,229	5,957,840		5,957,840	(236,504)	5,721,336			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 North of Bradley H & R

0052563

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,642)	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	(76,212)	30		9
10	Interest and Other Investment Income	(26)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(335)	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	(4,719)	21		18
19	Entertainment				19
20	Contributions	(2,850)	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	(182,039)	21		24
25	Fund Raising, Advertising and Promotional	(4,867)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(42,501)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (322,192)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	85,688		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,688		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (236,504)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

River North of Bradley H & R

Report Period Beginning: 01/01/14
 Ending: 12/31/14

ID# 0052563

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Sequestration Expense	\$ (31,090)	21	1
2	Bank Charges	(10,610)	21	2
3	PPA - Lab	(103)	39	3
4	PPA - Utilities	(547)	05	4
5	PPA - Repairs and Maintenance	(318)	06	5
6	PPA - Dietary Supplies	(80)	01	6
7	Non-allowable Legal	(13,182)	19	7
8	Additional R&M	15,922	06	8
9	PAC Dues	(894)	20	9
10	Non-allowable License (2015)	(250)	20	10
11	Non-allowable Seminar	(1,349)	24	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(42,501)	49

River North of Bradley H & R

Report Period Beginning: ID# 0052563
 Ending: 01/01/14
 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 North of Bradley H & R# 0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(80)											(80)	1
2	Food Purchase	(335)											(335)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,189)		906									(8,283)	5
6	Maintenance	15,604		5,388	5,394								26,386	6
7	Other (specify):*			174		560							734	7
8	TOTAL General Services	5,999		6,468	5,394	560							18,421	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records						(63)						(63)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs						(63)						(63)	16
	C. General Administration													
17	Administrative				85,647								85,647	17
18	Directors Fees													18
19	Professional Services	(13,182)		(118,841)									(132,023)	19
20	Fees, Subscriptions & Promotions	(8,861)		2,302									(6,559)	20
21	Clerical & General Office Expenses	(228,458)		57,280	7,523								(163,655)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,349)		827									(522)	24
25	Other Admin. Staff Transportation			2,972									2,972	25
26	Insurance-Prop.Liab.Malpractice			(1,028)									(1,028)	26
27	Other (specify):*			10,178		12,824							23,002	27
28	TOTAL General Administration	(251,850)		(46,310)	93,170	12,824							(192,166)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(245,850)		(39,842)	98,564	13,384	(63)						(173,807)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(76,212)		1,803									(74,409)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26)		1,548									1,522	32
33	Real Estate Taxes			3,101									3,101	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			8,371									8,371	35
36	Other (specify):*													36
37	TOTAL Ownership	(76,238)		14,823									(61,415)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(103)					(1,178)						(1,281)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(103)					(1,178)						(1,281)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(322,192)		(25,019)	98,564	13,384	(1,241)						(236,504)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 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 NO

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 906	\$	906	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	5,388		5,388	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	174		174	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	771		771	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	2,302		2,302	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	57,280		57,280	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	827		827	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,972		2,972	22
23	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	(1,028)		(1,028)	23
24	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	10,178		10,178	24
25	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,803		1,803	25
26	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,548		1,548	26
27	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,101		3,101	27
28	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	388		388	28
29	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	8,309		8,309	29
30	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	62		62	30
31	V								31
32	V	19 BOOKKEEPING FEES	120,000	DYNAMIC HEALTH CARE CONS.	100.00%			(120,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 120,000			\$ 94,981	\$ *	(25,019)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,394	\$	5,394	15
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	16,152		16,152	16
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	18,199		18,199	17
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				18
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	13,671		13,671	22
23	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	10,320		10,320	24
25	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	11,134		11,134	25
26	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	16,171		16,171	26
27	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,033		7,033	27
28	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	490		490	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		\$			\$ 98,564	\$ *	98,564	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 560	\$	560	15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	929		929	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,310		1,310	17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				18
19	V	27 EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	978		978	22
23	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,503		2,503	24
25	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	3,532		3,532	25
26	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,960		1,960	26
27	V	27 EMP. BEN.- S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,361		1,361	27
28	V	27 EMP. BEN.- E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	251		251	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		\$			\$ 13,384	\$ *	13,384	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING SUPPLIES	\$ 681	INTEGRA HEALTHCARE EQUIPMENT		\$ 618	\$ (63)
16	V	39 DME & MEDICAL SUPPLIES	12,756	INTEGRA HEALTHCARE EQUIPMENT		11,578	(1,178)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 13,437			\$ 12,196	\$ * (1,241)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BEN FRIEDMAN	30%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	Bradley Royale Building, LLC		BUILDING CO.	1
2	ELI LATINIK	4%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULTING	2
3	JONATHAN AARON	4%	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	ILANA AARON	7%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	4
5	FRED AARON	5%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	ESTHER MARYLES	30%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				6
7	CHANI MAUER	10%	WATERFRONT TERRACE, INC.	CHICAGO				7
8	MARSHALL & GILA MAUER	10%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				8
9			WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				9
10			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (GALESBURG					10
11			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLJ GENESEO					11
12			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF PONTIAC					12
13			WOODBIDGE NURSING PAVILION	CHICAGO				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 North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number River North of Bradley H & R # 0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Shareholder	Administrative	10.00%	See Attached	3.23	6.46%	Alloc. Salary	\$ 16,152	17-07	1
2	Maury Aaron	Relative	Administrative	0%	See Attached	3.64	7.28%	Alloc. Salary	18,199	17-07	2
3	Sharon Aaron	Relative	Clerical	0%	See Attached	3.23	8.08%	Alloc. Salary	7,033	21-07	3
4	Esther Maryles	Shareholder	Clerical	30.00%	See Attached	0.23	0.82%	Alloc. Salary	490	21-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 41,874		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 North of Bradley H & R

0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	452,396	14	\$ 11,795	\$ 34,750	\$ 906	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	452,396	14	70,149	38,885	34,750	5,388	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	452,396	14	2,266	34,750	174	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	14	10,039	34,750	771	4	
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	452,396	14	29,965	34,750	2,302	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	14	745,706	528,878	34,750	57,280	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	14	10,766	34,750	827	7	
8	25	AUTO EXP.	PATIENT DAYS	452,396	14	38,698	34,750	2,972	8	
9	26	INSURANCE	PATIENT DAYS	452,396	14	(13,379)	34,750	(1,028)	9	
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	452,396	14	132,506	34,750	10,178	10	
11	30	DEPRECIATION	PATIENT DAYS	452,396	14	23,478	34,750	1,803	11	
12	32	INTEREST	PATIENT DAYS	452,396	14	20,148	34,750	1,548	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	14	40,366	34,750	3,101	13	
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	452,396	14	5,056	34,750	388	14	
15	35	AUTO RENTAL	PATIENT DAYS	452,396	14	108,178	34,750	8,309	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	14	802	34,750	62	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,236,539	\$ 567,763	\$ 94,981	25	

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,284	59,284	3.64	5,394	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.23	16,152	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	3.64	18,199	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	11,000	11,000	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	60,271	60,271	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	103,196	103,196	-		6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	76,737	76,737	-		7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	9	150,258	150,258	4.55	13,671	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON-OW)	WGHTD. AVG. HOURS	40	11	127,632	127,632	3.23	10,320	10
11	17	ADMIN. CMP. - VAR. (NON-OW)	WGHTD. AVG. HOURS	45	9	129,197	129,197	3.86	11,134	11
12	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.23	16,171	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	87,119	87,119	3.23	7,033	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	60,541	60,541	0.23	490	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,477,235	\$ 1,477,235		\$ 98,564	25

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	6,150	3.64	\$ 560	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,498	3.23	928	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,402	3.64	1,311	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	37,628	-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,909	-		5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,033	-		6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	25,836	-		7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	9	10,754	4.55	978	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,085	-		9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	11	30,956	3.23	2,500	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	40,985	3.86	3,532	11
12	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	11	24,244	3.23	1,958	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	16,859	3.23	1,361	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	30,999	0.23	255	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 293,338	\$	\$ 13,383	25

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Integra Healthcare Equipment, LLC
 Street Address 747 Church Road
 City / State / Zip Code Elmhurst, IL 60126
 Phone Number (630) 834-3700
 Fax Number (630) 834-1500

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 618	1
2	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION					11,578	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				\$	\$		\$ 12,196	25

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River North of Bradley H & R

0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River North of Bradley H & R

0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	Allocated - Dynamic HC	X								\$ 1,548	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	MB Financial		X	Line of Credit		2/11/14		675,000	2/10/15	4.2500	5,720	6						
7	MB Financial		X	Note Payable		9/22/14		271,135	3/15/19	3.7406	409	7						
8	See Supplemental Schedule										6,000	8						
9	TOTAL Facility Related						\$	946,135			\$ 13,677	9						
B. Non-Facility Related*																		
10	Interest Income		X								(26)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$				\$ (26)	14						
15	TOTALS (line 9+line14)						\$	946,135			\$ 13,651	15						

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

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

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

Facility Name & ID Number

River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Remodeling Loan		X	Line of Credit			\$	\$			\$ 6,000					
9																
10																
11																
12																
13																
14	TOTAL Working Capital										6,000					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	82,872		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.)		\$	79,973		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,899)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	78,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	388		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.		\$	75,489		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY	
	2010	_____	9		
	2011	_____	10		
	2012	_____	11		
	2013	76,872	12		
Beginning Accrual Adjusted					
2014 Accrual - \$72,000 x 1.08 = \$78,000 (Rounded)				13	13
Allocated - Dynamic HC Consultants - \$3,101				14	14
				15	15
				16	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 North of Bradley H & R COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0052563

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-09-21-300-004</u>	<u>Long Term Care Property</u>	\$ <u>76,871.94</u>	\$ <u>76,971.94</u>
2. <u>10-23-404-059-0000</u>	<u>Allocated - Dynamic HC Consultants</u>	\$ <u>39,907.32</u>	\$ <u>3,065.41</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>116,779.26</u></u>	\$ <u><u>80,037.35</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		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 North of Bradley H & R

0052563 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,063 B. General Construction Type: Exterior Frame Brick Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			34,074	874	974	100	20,769	68
69				97,124		(97,124)		69
70			\$ 34,074	\$ 97,998		\$ 974	\$ (97,024)	\$ 20,769 70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 34,074	\$ 97,998		\$ 974	\$ (97,024)	\$ 20,769	1	
2	Remodeled Kitchen Hood Filter System	2,780		20	45	45	45	2	
3	Installed New Radiator	4,013		20	47	47	47	3	
4	Asphalt Back Lot And Front Lot, Replaced Concrete Ramps With A	52,010		20	278	278	278	4	
5	Insulation In The Entire Attic	3,032		20	10	10	10	5	
6	Tiles For Bathrooms (2 In Front & 2 In Back Of Building)	5,197		20	6	6	6	6	
7	Installed New Lightbox Sign	9,480		20	474	474	474	7	
8	Installed New Gaf Tpo Roofing System, Scuppers, And Front Gutt	167,750		20	8,388	8,388	8,388	8	
9	Marble For Bathroom Floors	5,119		20	256	256	256	9	
10	Install 6-Strand Multimode Fiber Optic Cable Between Mdf And I	19,691		20	985	985	985	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)	\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	34	

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	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		\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	34

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	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)	\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	34

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	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)		\$ 303,147	\$ 97,998		\$ 11,461	\$ (86,537)	\$ 31,256	34

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 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

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 - Dynamic HC Consultants	1993	34,074	874	35	974	100	20,769	3
4									4
5									5
6									6
7									7
8	Leasehold Information								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)		\$ 34,074	\$ 874		\$ 974	\$ 100	\$ 20,769	34

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 34,074	\$ 874		\$ 974	\$ 100	\$ 20,769	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)		\$ 34,074	\$ 874		\$ 974	\$ 100	\$ 20,769	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 10,446	\$ 48	\$ 1,619	\$ 1,571	10	\$ 5,099	71
72	Current Year Purchases	73,466	496	6,604	6,108	10	6,604	72
73	Fully Depreciated Assets	13,126		36	36	10	13,050	73
74								74
75	TOTALS	\$ 97,038	\$ 544	\$ 8,259	\$ 7,715		\$ 24,754	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		Allocated - Dynamic HC Consult	1905	\$ 18,104	\$ 386	\$ 2,996	\$ 2,610	5	\$ 11,430	76
77										77
78										78
79										79
80	TOTALS			\$ 18,104	\$ 386	\$ 2,996	\$ 2,610		\$ 11,430	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)	\$ 418,288	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,928	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,716	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (76,212)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 67,439	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	Invacare	\$ 41,520	92
93	Prefontaine & Associates	50,000	93
94			94
95		\$ 91,520	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 North of Bradley H & R

0052563

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Bradley Royale

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>615,900</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>615,900</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____ by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 11,155

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	<u>Facility</u>	<u>2013 Lexus</u>	\$ <u>837.16</u>	\$ <u>10,046</u>	17
18	<u>Allocated - Dynamic HC Consultants</u>			<u>8,309</u>	18
19					19
20					20
21	TOTAL		\$ <u>837.16</u>	\$ <u>18,355</u>	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 North of Bradley H & R # 0052563 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 538		\$ 241,778										1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			134,046										2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 01	hrs	887		274,103										4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							166,956					166,956	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>						12,124			17,263					29,387	13
14	TOTAL			\$ 1,425		\$ 662,051				\$ 184,219				\$ 847,695		14

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

Facility Name & ID Number River North of Bradley H & R# 0052563Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 605,456	\$	1
2	Cash-Patient Deposits	2,002		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,684,862		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,435		6
7	Other Prepaid Expenses	6,003		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	127,982		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,521,740	\$	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	272,801		15
16	Equipment, at Historical Cost	88,682		16
17	Accumulated Depreciation (book methods)	(100,416)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,098,258		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,359,325	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,881,065	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 680,769	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,311		28
29	Short-Term Notes Payable	946,135		29
30	Accrued Salaries Payable	125,822		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,011		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,000		32
33	Accrued Interest Payable	1,906		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,002		35
	Other Current Liabilities(specify):			
36	See Attached Schedule	539,823		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,392,779	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,392,779	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,488,286	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,881,065	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 663,624	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 663,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	968,662	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	(144,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 824,662	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,488,286	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,423,499	1
2	Discounts and Allowances for all Levels	(1,979,665)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,443,834	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,136,400	6
7	Oxygen	2,264	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,138,664	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	250,185	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,957	19
20	Radiology and X-Ray	3,400	20
21	Other Medical Services	34,350	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 301,892	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 112	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	42,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 42,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,926,502	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,022,681	31
32	Health Care	1,834,487	32
33	General Administration	1,181,908	33
B. Capital Expense			
34	Ownership	818,291	34
C. Ancillary Expense			
35	Special Cost Centers	847,695	35
36	Provider Participation Fee	252,778	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,957,840	40
41	Income before Income Taxes (line 30 minus line 40)**	968,662	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 968,662	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,022,267	44
45	Private Pay - Net Inpatient Revenue	776,194	45
46	Medicare - Net Inpatient Revenue	202,121	46
47	Other-(specify) <u>Hospice</u>	443,252	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,443,834	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,921	2,112	\$ 72,001	\$ 34.09	1
2	Assistant Director of Nursing	2,183	2,199	63,354	28.81	2
3	Registered Nurses	15,624	16,812	372,791	22.17	3
4	Licensed Practical Nurses	13,296	13,792	276,169	20.02	4
5	CNAs & Orderlies	64,863	67,544	711,731	10.54	5
6	CNA Trainees					6
7	Licensed Therapist	22	22	1,425	64.77	7
8	Rehab/Therapy Aides	840	880	12,506	14.21	8
9	Activity Director	1,950	2,014	25,286	12.56	9
10	Activity Assistants	7,735	8,343	76,865	9.21	10
11	Social Service Workers	3,892	4,084	56,642	13.87	11
12	Dietician					12
13	Food Service Supervisor	200	200	3,282	16.41	13
14	Head Cook	423	481	6,516	13.55	14
15	Cook Helpers/Assistants	471	507	4,711	9.29	15
16	Dishwashers					16
17	Maintenance Workers	2,744	2,784	46,458	16.69	17
18	Housekeepers	1,373	1,690	14,538	8.60	18
19	Laundry	505	562	4,767	8.48	19
20	Administrator	2,080	2,080	153,979	74.03	20
21	Assistant Administrator	1,680	1,680	51,652	30.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,463	4,690	60,877	12.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,991	2,095	26,398	12.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,256	134,571	\$ 2,041,948 *	\$ 15.17	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	11	\$ 702	01-03	35
36	Medical Director	66	6,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	134	8,250	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	61	3,059	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Outside Dietary Services		230,200	01-03	48
49	TOTAL (lines 35 - 48)	272	\$ 248,811		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ben Friedman	Administrator	30%	\$ 153,979	Workers' Compensation Insurance	\$ 60,743	IDPH License Fee	\$	
Jennifer Hope	Asst. Administrator		51,653	Unemployment Compensation Insurance	10,309	Advertising: Employee Recruitment	9,572	
				FICA Taxes	155,304	Health Care Worker Background Check	1,180	
				Employee Health Insurance	38,064	(Indicate # of checks performed <u>118</u>)		
				Employee Meals	9,329	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	1,815	
				Other Employee Benefits	12,198	Licenses and Permits	3,787	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated - Dynamic HC Consultants	2,302	
(List each licensed administrator separately.)			\$ 205,632			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees			\$ 17,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 17,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 285,947	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,656	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg, Rothblatt	Accounting		\$ 22,929				Out-of-State Travel	\$
Dynamic HC Consultants	Bookkeeping / Home Office		120,000					
Health Data Systems	Clinical / E.H.R.		6,117					
NTT Data LTC Solutions	Data Processing		14,015				In-State Travel	
Dynamic HC Consultants	Data Processing		2,982					
Ability	Billing Management		162					
Casamba	EMR for Therapy		2,100					
Personnel Planners	Unemployment Consulting		1,700				Seminar Expense	7,802
Legal	See Attached		18,336				Allocated - Dynamic HC Consultants	827
Penny Varnavas	Management Consultant		10,150					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 198,492				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 8,629

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number River North of Bradley H & R

0052563

Report Period Beginning:

01/01/14

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. ICLTC \$2,709
- (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. \$ 31,231 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. \$ 252,778
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. \$ 9,329 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% LN 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.