FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052175

Facility Name: Rivershores Hlth & Rehab Ctr

Address: 578 W Commercial St (Number) Marseilles (City) 61341 (Zip Code)

County: Lasalle

Telephone Number: (815) 795-5121 **Fax #** (815) 795-6213

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,335		5,205	29,540	8
9	SNF/PED					9
10	ICF		1,956		1,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,335	1,956	5,205	31,496	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.78%

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)
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 103 and days of care provided 3,938

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	189,137	42,602	7,576	239,315		239,315	48	239,363			1
2	Food Purchase		170,533		170,533		170,533	(3,453)	167,080			2
3	Housekeeping	121,436	24,202		145,638		145,638	818	146,456			3
4	Laundry	41,753	11,407	734	53,894		53,894		53,894			4
5	Heat and Other Utilities			101,953	101,953		101,953	1,208	103,161			5
6	Maintenance	48,414	12,087	60,160	120,661		120,661	(27,260)	93,401			6
7	Other (specify):*											7
8	**TOTAL General Services**	400,740	260,831	170,423	831,994		831,994	(28,639)	803,355			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	4,727	16,727			9
10	Nursing and Medical Records	1,659,003	118,750	39,503	1,817,256		1,817,256	21,050	1,838,306			10
10a	Therapy	38,568		27,956	66,524		66,524		66,524			10a
11	Activities	104,178	11,322	1,046	116,546		116,546	9	116,555			11
12	Social Services	63,971			63,971		63,971	3,209	67,180			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,174	3,174			15
16	**TOTAL Health Care and Programs**	1,865,720	130,072	80,505	2,076,297		2,076,297	32,169	2,108,466			16
	C. General Administration											
17	Administrative	82,857		98,232	181,089		181,089	13,578	194,667			17
18	Directors Fees											18
19	Professional Services			194,338	194,338	(1,874)	192,464	(105,838)	86,626			19
20	Dues, Fees, Subscriptions & Promotions			75,028	75,028		75,028	(38,863)	36,165			20
21	Clerical & General Office Expenses	109,571	28,196	706,144	843,911		843,911	(535,822)	308,089			21
22	Employee Benefits & Payroll Taxes			392,054	392,054		392,054		392,054			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,252	3,252		3,252	95	3,347			24
25	Other Admin. Staff Transportation			15,236	15,236		15,236	2,332	17,568			25
26	Insurance-Prop.Liab.Malpractice			42,891	42,891		42,891	420	43,311			26
27	Other (specify):*							26,368	26,368			27
28	**TOTAL General Administration**	192,428	28,196	1,527,175	1,747,799	(1,874)	1,745,925	(637,730)	1,108,195			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,458,888	419,099	1,778,103	4,656,090	(1,874)	4,654,216	(634,200)	4,020,016			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 Rivershores Hlth & Rehab Ctr #0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			10,118	10,118		10,118	117,514	127,632			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,739	55,739		55,739	305,683	361,422			32
33	Real Estate Taxes			48,642	48,642	1,874	50,516	2,509	53,025			33
34	Rent-Facility & Grounds			337,125	337,125		337,125	(337,125)				34
35	Rent-Equipment & Vehicles			8,576	8,576		8,576	260	8,836			35
36	Other (specify):*			(154,957)	(154,957)		(154,957)	154,957				36
37	**TOTAL Ownership**			305,243	305,243	1,874	307,117	243,798	550,915			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,114	479,911	624,025		624,025		624,025			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,670	223,670		223,670		223,670			42
43	Other (specify):*	29,729		20,140	49,869		49,869	(49,869)	0			43
44	**TOTAL Special Cost Centers**	29,729	144,114	723,721	897,564		897,564	(49,869)	847,695			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,488,617	563,213	2,807,067	5,858,897		5,858,897	(440,271)	5,418,626			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 Rivershores Hlth & Rehab Ctr # 0052175 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,348)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(69,226)	30		9
10	Interest and Other Investment Income	(4,811)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(105)	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				18
19	Entertainment				19
20	Contributions	(2,449)	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	(524,212)	21		24
25	Fund Raising, Advertising and Promotional	(35,664)	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	(211,416)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (851,231)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	410,960		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 410,960		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (440,271)		37

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

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

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

Rivershores Hlth & Rehab Ctr

ID# 0052175

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (28,476)	21	1
2	Marketing Consultant	(20,140)	43	2
3	Bank Charges	(7,408)	21	3
4	Marketing Salaries	(29,729)	43	4
5	Penalty - Late Fees	(895)	21	5
6	Theft & Loss	(2,876)	21	6
7	Vending Income	(1,848)	21	7
8	Misc. Income	(1,858)	21	8
9	Prior Period Expense	(38,456)	21	9
10	Additional R&M	3,668	06	10
11	Capitalized R&M	(34,127)	06	11
12	Amortization Expense - Building Co.	(41,800)	31	12
13	Non-Allowable Legal Services	(4,236)	19	13
14	PAC Dues	(3,236)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(211,416)		49

Rivershores Hlth & Rehab Ctr

ID# 0052175

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			48									48	1
2	Food Purchase	(3,453)											(3,453)	2
3	Housekeeping			818									818	3
4	Laundry													4
5	Heat and Other Utilities			867	341								1,208	5
6	Maintenance	(30,459)		3,067	132								(27,260)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(33,912)		4,800	473								(28,639)	8
	B. Health Care and Programs													
9	Medical Director			4,727									4,727	9
10	Nursing and Medical Records			21,050									21,050	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services			3,209									3,209	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,174									3,174	15
16	**TOTAL Health Care and Programs**			32,169									32,169	16
	C. General Administration													
17	Administrative			69,797		(56,219)							13,578	17
18	Directors Fees													18
19	Professional Services	(4,236)		(102,082)	286	194							(105,838)	19
20	Fees, Subscriptions & Promotions	(41,349)		2,479	7								(38,863)	20
21	Clerical & General Office Expenses	(606,028)	126	70,031	25	24							(535,822)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			95									95	24
25	Other Admin. Staff Transportation			592		1,740							2,332	25
26	Insurance-Prop.Liab.Malpractice			266	154								420	26
27	Other (specify):*			26,368									26,368	27
28	**TOTAL General Administration**	(651,613)	126	67,546	472	(54,261)							(637,730)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(685,525)	126	104,515	945	(54,261)							(634,200)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rivershores Hlth & Rehab Ctr **#** 0052175 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(69,226)	181,476	3,724	1,540								117,514	30
31	Amortization of Pre-Op. & Org.	(41,800)	41,800											31
32	Interest	(4,811)	307,320	78	3,096								305,683	32
33	Real Estate Taxes				2,509								2,509	33
34	Rent-Facility & Grounds		(337,125)	11,053	(11,053)								(337,125)	34
35	Rent-Equipment & Vehicles			260									260	35
36	Other (specify):*		154,957										154,957	36
37	**TOTAL Ownership**	(115,837)	348,428	15,115	(3,908)								243,798	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,869)											(49,869)	43
44	**TOTAL Special Cost Centers**	(49,869)											(49,869)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(851,231)	348,554	119,630	(2,963)	(54,261)							(440,271)	45

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 337,125	RHRC Realty, LLC		$	$ (337,125)	1
2	V	31	Amortization Expense		RHRC Realty, LLC		41,800	41,800	2
3	V	30	Depreciation Expense		RHRC Realty, LLC		181,476	181,476	3
4	V	32	Interest Expense		RHRC Realty, LLC		307,320	307,320	4
5	V	21	Other Expense		RHRC Realty, LLC		126	126	5
6	V	36	Loss on Inercompany Loan		RHRC Realty, LLC		154,957	154,957	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 337,125			$ 685,679	$ * 348,554	14

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 48	$ 48	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	818	818	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	867	867	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,067	3,067	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	4,727	4,727	19
20	V	10	NURSING SALARIES/CONSULT	12,360	MANAGCARE, INC.	100.00%	33,410	21,050	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	9	9	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	3,209	3,209	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	3,174	3,174	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	69,797	69,797	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	2,978	2,978	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	2,479	2,479	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	65,285	65,285	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	4,746	4,746	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	95	95	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	592	592	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	266	266	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	26,368	26,368	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	3,724	3,724	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	78	78	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,053	11,053	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	260	260	36
37	V	19	ADMINISTRATIVE CONSULTANT	18,540	MANAGCARE, INC.	100.00%		(18,540)	37
38	V	19	BOOKKEEPING	86,520	MANAGCARE, INC.	100.00%		(86,520)	38
39	Total			$ 117,420			$ 237,050	$ * 119,630	39

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 341	$ 341	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	132	132	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	286	286	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	7	7	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	25	25	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	154	154	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,540	1,540	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	3,096	3,096	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,509	2,509	23
24	V								24
25	V	34	RENT	11,053	4600 TOUHY, LLC	100.00%		(11,053)	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			$ 11,053			$ 8,090	$ * (2,963)	39

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 12,927	$ 12,927	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	12,927	12,927	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	12,927	12,927	17
18	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	194	194	18
19	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	24	24	19
20	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	1,740	1,740	20
21	V	17	ADMINISTRATIVE FEES - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	3,232	3,232	21
22	V	17	MANAGEMENT FEES	98,232	TETRAD MANAGEMENT, LLC	100.00%		(98,232)	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			$ 98,232			$ 43,971	$ * (54,261)	39

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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 Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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	Central Illinois Operations, LLC	99.99%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	RHRC Realty, LLC	LINCOLNWOOD	BUILDING COMPANY	1
2	Tetrad Management, LLC	0.01%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3			MAYFIELD CARE CENTER, INC.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4			CAPITOL HEALTHCARE & REHABILITATION CENTRE	SPRINGFIELD, IL	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL				5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILTATION CENTRE	MORTON, IL				7
8			MID AMERICA CARE CENTER, LLC	CHICAGO				8
9			MORTON TERRACE HEALTHCARE & REHABILITATION CETNRE	MORTON, IL				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 Rivershores Hlth & Rehab Ctr # 0052175 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 Rivershores Hlth & Rehab Ctr # 0052175 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Moshe Davis	Relative	Mgmt /Admin	0.00%	See Attached	2.84	6.45%	Alloc. Fees	$ 12,927	17-7	1
2	Yehoshua Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.1	6.46%	Alloc. Fees	12,927	17-7	2
3	Nesanel Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.1	6.46%	Alloc. Fees	12,927	17-7	3
4	Eli Davis	Relative	Mgmt /Admin	0.00%	See Attached	2.59	6.48%	Alloc. Fees	3,232	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 42,013		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 Rivershores Hlth & Rehab Ctr # 0052175 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 [X]

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 [X] NO [ ]

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

Name of Related Organization: MANAGCARE, INC.
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	487,280	10	$ 748	$	31,496	$ 48	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		31,496	818	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		31,496	867	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		31,496	3,067	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		31,496	4,727	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	31,496	33,410	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		31,496	9	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	31,496	3,209	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		31,496	3,174	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	31,496	69,797	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		31,496	2,978	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		31,496	2,479	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	31,496	65,285	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		31,496	4,746	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		31,496	95	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		31,496	592	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		31,496	266	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		31,496	26,368	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		31,496	3,724	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		31,496	78	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		31,496	11,053	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		31,496	260	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 237,050	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 [X] NO [ ]

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

Name of Related Organization: 4600 TOUHY, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((773) 463-1313
Fax Number: ((773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	487,280	10	$ 5,277	$	31,496	$ 341	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		31,496	132	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		31,496	286	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		31,496	7	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		31,496	25	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		31,496	154	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		31,496	1,540	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		31,496	3,096	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		31,496	2,509	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					$ 125,196	$		$ 8,090	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 [X] NO [ ]

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

Name of Related Organization: TETRAD MANAGEMENT, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	$ 200,000	$ 200,000	31,496	$ 12,927	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	31,496	12,927	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	31,496	12,927	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		31,496	194	4
5	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		31,496	24	5
6	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		31,496	1,740	6
7	17	ADMINISTRATIVE FEE - ELI	PATIENT DAYS	487,280	10	50,000		31,496	3,232	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					$ 680,288	$ 600,000		$ 43,971	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Note Payble			$	$			$ 240,628	1
2	Greystone		X								66,692	2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X								51,721	6
7	Other Interest		X								4,018	7
8	See Supplemental Schedule										3,174	8
9	TOTAL Facility Related						$	$			$ 366,233	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,811)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,811)	14
15	TOTALS (line 9+line14)						$	$			$ 361,422	15

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

*** 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 Rivershores Hlth & Rehab Ctr # 0052175 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Managcare Inc.		X				$	$			$ 78	8
9	Allocated from 4600 Touhy LLC		X								3,096	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,174	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,265	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.)		$ 51,151	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,886	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,265	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.)**		$ 1,874	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.		$ 53,025	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012	46,678	11
2013	48,642	12

2013 Accrual = $48,642 x 0.99 = $48,265 (Rounded)

Allocated from 4600 Touhy LLC: $2,509

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rivershores Hlth & Rehab Ctr COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-49-325-027	Long Term Care Property	$ 47,983.06	$ 47,983.06
2.	15-49-325-026	Long Term Care Property	$ 658.88	$ 658.88
3.	See Attached	See Attached	$ 84,567.54	$ 2,733.07
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,209.48	$ 51,375.01

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rivershores Hlth & Rehab Ctr COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,830 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 1

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 217,814	1
2					2
3	TOTALS			$ 217,814	3

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103		2013	1967	$ 1,765,573	$ 181,476	39	$ 45,271	$ (136,205)	$ 90,542	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 Rivershores Hlth & Rehab Ctr # 0052175 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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		67,765	2,183		2,735	552	8,166	68
69	Financial Statement Depreciation			10,118			(10,118)		69
70	TOTAL (lines 4 thru 69)		$ 1,833,338	$ 193,777		$ 48,006	$ (145,771)	$ 98,708	70

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12A, Carried Forward		$ 1,833,338	$ 193,777		$ 48,006	$ (145,771)	$ 98,708	1
2	Water Boiler	2013	6,725		20	336	336	588	2
3	Water Heater	2013	9,400		20	470	470	666	3
4	Water Heater Repair	2013	3,011		20	151	151	276	4
5	Generator Repair	2013	2,611		20	131	131	250	5
6	Wiring For Telecom	2014	7,176		20	513	513	513	6
7	Piping	2014	3,391		20	170	170	170	7
8	Piping	2014	3,026		20	151	151	151	8
9	New Rooftop A/C Unit	2014	3,020		20	151	151	151	9
10	Flooring For Patio And Resident Room	2014	7,253		20	363	363	363	10
11	Sinage	2014	6,858		20	343	343	343	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)		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12B, Carried Forward		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	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)		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12C, Carried Forward		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	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)		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12D, Carried Forward		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	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)		$ 1,885,809	$ 193,777		$ 50,783	$ (142,994)	$ 102,178	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	33,188	851	20	1,006	155	3,319	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare Inc.	2013	557	148	20	28	(120)	56	9
10	Allocated from Managcare Inc.	2012	6,929	495	20	346	(149)	1,039	10
11									11
12	Allocated from 4600 Touhy LLC	2012	21,373	554	20	1,069	515	3,206	12
13	Allocated from 4600 Touhy LLC	2013	5,201	122	20	260	138	520	13
14	Allocated from 4600 Touhy LLC	2014	517	13	20	26	13	26	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)		$ 67,765	$ 2,183		$ 2,735	$ 552	$ 8,166	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 12H, Carried Forward		$ 67,765	$ 2,183		$ 2,735	$ 552	$ 8,166	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)		$ 67,765	$ 2,183		$ 2,735	$ 552	$ 8,166	34

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 694,702	$ 2,702	$ 71,656	$ 68,954	10	$ 142,541	71
72	Current Year Purchases	38,272		4,305	4,305	10	4,305	72
73	Fully Depreciated Assets	15,920				10	15,920	73
74								74
75	TOTALS	$ 748,894	$ 2,702	$ 75,961	$ 73,259		$ 162,766	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 from Managcare Inc.	2014	$ 7,812	$ 378	$ 887	$ 509	5	$ 7,143	76
77										77
78										78
79										79
80	TOTALS			$ 7,812	$ 378	$ 887	$ 509		$ 7,143	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)	$ 2,860,329	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 196,857	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,631	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,226)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 272,087	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,144 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	Facility	2014 Champion	$	$ 6,692	17
18		Challenger Bus			18
19					19
20					20
21	TOTAL		$	$ 6,692	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 Rivershores Hlth & Rehab Ctr # 0052175 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.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 176,065	$		$ 176,065	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			48,554			48,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			225,592			225,592	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				140,832		140,832	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					29,700	3,282		32,982	13
14	TOTAL			$		$ 479,911	$ 144,114		$ 624,025	14

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

STATE OF ILLINOIS

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 184,136	$	1
2	Cash-Patient Deposits	17,985		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,911,801		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,412		6
7	Other Prepaid Expenses	77,389		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	147,007		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,418,730	$	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	50,122		15
16	Equipment, at Historical Cost	99,780		16
17	Accumulated Depreciation (book methods)	(15,429)		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):	232,450		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 366,923	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,785,653	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 469,666	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,985		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,234		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,031		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,265		32
33	Accrued Interest Payable	1,612		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	167,299		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 829,092	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,483,282		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,483,282	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,312,374	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 473,279	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,785,653	$	48

***(See instructions.)**

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 119,885	1	
2	Restatements (describe):		2	
3	**Rounding**	6	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 119,891	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	353,388	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 353,388	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)**	$ 473,279	24	*

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,081,742	1
2	Discounts and Allowances for all Levels	(1,136,327)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,945,415	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,093,392	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,093,392	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	3,348	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,245	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,447	19
20	Radiology and X-Ray	4,220	20
21	Other Medical Services	2,484	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 165,744	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,811	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,811	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,923	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,923	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,212,285	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,994	31
32	Health Care	2,076,297	32
33	General Administration	1,747,799	33
	B. Capital Expense		
34	Ownership	305,243	34
	C. Ancillary Expense		
35	Special Cost Centers	673,894	35
36	Provider Participation Fee	223,670	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,858,897	40
41	**Income before Income Taxes (line 30 minus line 40)****	353,388	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 353,388	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,506,642	44
45	Private Pay - Net Inpatient Revenue	382,947	45
46	Medicare - Net Inpatient Revenue	857,923	46
47	Other-(specify) Hospice	169,336	47
48	Other-(specify) Insurance	28,567	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,945,415	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,017	2,049	$ 65,840	$ 32.13	1
2	Assistant Director of Nursing	1,800	1,851	53,308	28.80	2
3	Registered Nurses	15,065	16,674	439,405	26.35	3
4	Licensed Practical Nurses	14,353	16,061	351,877	21.91	4
5	CNAs & Orderlies	58,436	65,569	724,534	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,876	3,357	38,568	11.49	8
9	Activity Director	2,024	2,180	46,039	21.12	9
10	Activity Assistants	6,253	6,660	58,139	8.73	10
11	Social Service Workers	3,624	3,760	63,971	17.01	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,200	30,634	13.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,504	16,530	158,503	9.59	15
16	Dishwashers					16
17	Maintenance Workers	2,183	2,450	48,414	19.76	17
18	Housekeepers	12,272	13,367	121,436	9.08	18
19	Laundry	3,816	4,208	41,753	9.92	19
20	Administrator	2,032	2,170	82,857	38.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,368	8,849	109,571	12.38	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	1,876	2,120	24,039	11.34	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,109	1,109	29,729	26.81	33
34	TOTAL (lines 1 - 33)	155,664	171,164	$ 2,488,617 *	$ 14.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,576	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Quarterly	1,470	10-03	37
38	Nurse Consultant	Monthly	12,360	10-03	38
39	Pharmacist Consultant	Monthly	7,133	10-03	39
40	Physical Therapy Consultant	Monthly	143	10a-03	40
41	Occupational Therapy Consultant	Monthly	595	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,046	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Renal Therapy Consultant	Monthly	27,218	10a-03	47
48	MDS Consultant	Monthly	18,540	10-03	48
49	TOTAL (lines 35 - 48)		$ 88,081		49

C. CONTRACT NURSES

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tina McCoy	Administrator	0	$ 82,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,857

B. Administrative - Other

Description	Amount
Tetrad Management - Management Fees	$ 98,232
TOTAL (agree to Schedule V, line 17, col. 3)	$ 98,232
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 14,625
Personnel Planners	Unemployment Consultant	3,201
Managcare, Inc	Bookkeeping	86,520
See Attached	Legal	19,384
Managcare, Inc	Administrative Consultant	18,540
Provinet Solutions	Computer Services	6,084
Onward Consult	IT Consulting	5,040
FRS HC Consulting	Healthcare Consulting	1,500
Mgmt & Network Services	Computer Services	500
Smartlinks	Computer Services	1,780
Ability	Computer Services	3,644
See Supplemental Schedule		33,521
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 194,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,856
Unemployment Compensation Insurance	71,153
FICA Taxes	186,115
Employee Health Insurance	56,035
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Safe Harbor Match Expense	26,961
Holiday Expense	4,657
Other Employee Benefits	16,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 392,054

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,957
Health Care Worker Background Check	
(Indicate # of checks performed 250.5)	5,010
Patient Background Checks	
Licenses & Permits	3,760
Dues & Subscriptions	8,952
Allocated from Managcare Inc.	2,479
Allocated from 4600 Touhy LLC	7
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,165

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,252
Allocated from Managcare Inc.	95
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,347

**See instructions.

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Rivershores Hlth & Rehab Ctr # 0052175 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $9,805**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,041** Line **10**

(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. $ **223,670**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
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?
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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.