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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052761

Facility Name: River Crossing Rehab, Llc

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

County: Knox

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,297	532	1,312	7,141	8
9	SNF/PED					9
10	ICF	23,515	61	1,747	25,323	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,812	593	3,059	32,464	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.35%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 952

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,472	19,227	17,531	148,230		148,230	7,524	155,754			1
2	Food Purchase		180,975		180,975		180,975	151	181,126			2
3	Housekeeping	107,367	26,590		133,957		133,957		133,957			3
4	Laundry	43,228	9,482		52,710		52,710		52,710			4
5	Heat and Other Utilities			107,323	107,323		107,323	(7,787)	99,536			5
6	Maintenance	65,482	17,991	80,359	163,832		163,832	13,183	177,015			6
7	Other (specify):*							1,902	1,902			7
8	**TOTAL General Services**	327,549	254,265	205,213	787,027		787,027	14,972	801,999			8
	B. Health Care and Programs											
9	Medical Director			24,750	24,750		24,750		24,750			9
10	Nursing and Medical Records	1,205,971	256,757	39,762	1,502,490		1,502,490	9,832	1,512,322			10
10a	Therapy	219,739	5,786	650	226,175		226,175		226,175			10a
11	Activities	32,463	1,482	748	34,693		34,693		34,693			11
12	Social Services	147,395		2,503	149,898		149,898		149,898			12
13	CNA Training											13
14	Program Transportation			87	87		87		87			14
15	Other (specify):*							4,371	4,371			15
16	**TOTAL Health Care and Programs**	1,605,568	264,025	68,500	1,938,093		1,938,093	14,203	1,952,296			16
	C. General Administration											
17	Administrative	71,089		276,353	347,442		347,442	(217,763)	129,679			17
18	Directors Fees											18
19	Professional Services			276,354	276,354		276,354	(182,801)	93,553			19
20	Dues, Fees, Subscriptions & Promotions			63,079	63,079		63,079	(36,453)	26,626			20
21	Clerical & General Office Expenses	41,871		455,259	497,130		497,130	(330,930)	166,200			21
22	Employee Benefits & Payroll Taxes			282,998	282,998		282,998		282,998			22
23	Inservice Training & Education											23
24	Travel and Seminar			572	572		572	4,802	5,374			24
25	Other Admin. Staff Transportation			5,107	5,107		5,107	8,890	13,997			25
26	Insurance-Prop.Liab.Malpractice			112,055	112,055		112,055	8,556	120,611			26
27	Other (specify):*							5,282	5,282			27
28	**TOTAL General Administration**	112,960		1,471,777	1,584,737		1,584,737	(740,417)	844,320			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,046,077	518,290	1,745,490	4,309,857		4,309,857	(711,242)	3,598,615			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number River Crossing Rehab, Llc #0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			70,160	70,160		70,160	45,651	115,811			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,758	40,758		40,758	54,966	95,724			32
33	Real Estate Taxes			14,478	14,478		14,478	16,756	31,234			33
34	Rent-Facility & Grounds			405,828	405,828		405,828	(405,281)	547			34
35	Rent-Equipment & Vehicles			5,699	5,699		5,699	4,090	9,789			35
36	Other (specify):*			18,874	18,874		18,874	(18,874)	0			36
37	**TOTAL Ownership**			555,797	555,797		555,797	(302,692)	253,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		839	363,124	363,963		363,963	(3,153)	360,810			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			233,003	233,003		233,003		233,003			42
43	Other (specify):*			36,904	36,904		36,904	(34,861)	2,043			43
44	**TOTAL Special Cost Centers**		839	633,031	633,870		633,870	(38,014)	595,856			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,046,077	519,129	2,934,318	5,499,524		5,499,524	(1,051,948)	4,447,576			45

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,304)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,440)	30		9
10	Interest and Other Investment Income	(3,900)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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	(27,883)	21		18
19	Entertainment	(555)	21		19
20	Contributions	(33,300)	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	(374,902)	21		24
25	Fund Raising, Advertising and Promotional	(26,861)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(81,208)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (558,386)		$	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)	(493,562)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (493,562)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,051,948)		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

River Crossing Rehab, Llc

ID# 0052761

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 10,003	06	1
2	Bank Charges	(10,444)	21	2
3	Amortization	(18,874)	36	3
4	Jury Duty Income	(60)	10	4
5	Other Unclassified Income	(1,095)	21	5
6	Non-Allowable Professional Fees	(8,000)	43	6
7	PAC Dues	(6,313)	20	7
8	Building Co - Amortization	(6,706)	36	8
9	Building Co - Bank Charges	(1,135)	21	9
10	Non-Allowable Legal	(2,244)	19	10
11	Capitalized R&M	(4,340)	06	11
12	Non-Allowable Rent	(32,000)	34	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(81,208)		49

River Crossing Rehab, Llc

ID# 0052761

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number River Crossing Rehab, Llc **#** 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				7,524								7,524	1
2	Food Purchase	(33)		184									151	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,304)		6			511						(7,787)	5
6	Maintenance	5,663		4,383	2,366	16	755						13,183	6
7	Other (specify):*			282	1,620								1,902	7
8	**TOTAL General Services**	(2,674)		4,855	11,510	16	1,265						14,972	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(60)		3,972	5,920								9,832	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			283	4,088								4,371	15
16	**TOTAL Health Care and Programs**	(60)		4,255	10,008								14,203	16
	C. General Administration													
17	Administrative			(220,617)		2,853							(217,763)	17
18	Directors Fees													18
19	Professional Services	(2,244)		(96,764)	734	(81,659)	172	(3,040)					(182,801)	19
20	Fees, Subscriptions & Promotions	(39,613)		1,843	1,257	49	11						(36,453)	20
21	Clerical & General Office Expenses	(416,014)	1,135	31,550	1,320	50,068	1,011						(330,930)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,452	256	94							4,802	24
25	Other Admin. Staff Transportation			5,270	2,939	681							8,890	25
26	Insurance-Prop.Liab.Malpractice			1,445		7,111							8,556	26
27	Other (specify):*			5,164	118								5,282	27
28	**TOTAL General Administration**	(457,871)	1,135	(267,657)	6,624	(20,803)	1,195	(3,040)					(740,417)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(460,605)	1,135	(258,547)	28,141	(20,787)	2,460	(3,040)					(711,242)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,440)	44,459	543	61		2,028						45,651	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,900)	53,292	4,002	18		1,554						54,966	32
33	Real Estate Taxes		14,770				1,986						16,756	33
34	Rent-Facility & Grounds	(32,000)	(361,828)	283			(11,736)						(405,281)	34
35	Rent-Equipment & Vehicles			2,757	441	321	572						4,090	35
36	Other (specify):*	(25,580)	6,706										(18,874)	36
37	TOTAL Ownership	(62,919)	(242,601)	7,584	520	321	(5,596)						(302,692)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(3,153)				(3,153)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(34,861)											(34,861)	43
44	TOTAL Special Cost Centers	(34,861)							(3,153)				(38,014)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(558,386)	(241,466)	(250,962)	28,661	(20,466)	(3,136)	(3,040)	(3,153)				(1,051,948)	45

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Rent	$ 361,828	1145 Frank St. LLC	100.00%	$	$ (361,828)	1
2	V	32	Interest	1	1145 Frank St. LLC	100.00%	53,293	53,292	2
3	V	36	Amortization		1145 Frank St. LLC	100.00%	6,706	6,706	3
4	V	21	Bank Charges		1145 Frank St. LLC	100.00%	1,135	1,135	4
5	V	30	Depreciation		1145 Frank St. LLC	100.00%	44,459	44,459	5
6	V	33	Real Estate Tax		1145 Frank St. LLC	100.00%	14,770	14,770	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 361,829			$ 120,363	$ * (241,466)	14

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	2	FOOD	$	APERION CARE	100.00%	$ 184	$ 184	15
16	V	5	UTILITIES		APERION CARE	100.00%	6	6	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE	100.00%	4,383	4,383	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	282	282	18
19	V	10	SALARY- NURSE		APERION CARE	100.00%	3,972	3,972	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	283	283	20
21	V	17	ADMINISTRATIVE		APERION CARE	100.00%	55,737	55,737	21
22	V	19	PROFESSIONAL FEES		APERION CARE	100.00%	11,094	11,094	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,843	1,843	23
24	V	21	CLERICAL & GENERAL		APERION CARE	100.00%	31,550	31,550	24
25	V	24	SEMINARS		APERION CARE	100.00%	4,452	4,452	25
26	V	25	AUTO AND TRAVEL		APERION CARE	100.00%	5,270	5,270	26
27	V	26	INSURANCE		APERION CARE	100.00%	1,445	1,445	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	5,164	5,164	28
29	V	30	DEPRECIATION		APERION CARE	100.00%	543	543	29
30	V	32	INTEREST		APERION CARE	100.00%	4,002	4,002	30
31	V	33	REAL ESTATE TAX		APERION CARE	100.00%			31
32	V	34	RENT		APERION CARE	100.00%	283	283	32
33	V	35	EQUIPMENT RENTAL		APERION CARE	100.00%	87	87	33
34	V	35	AUTO LEASE		APERION CARE	100.00%	2,670	2,670	34
35	V	17	MANAGEMENT FEE	276,353	APERION CARE	100.00%		(276,353)	35
36	V	19	HOME OFFICE	100,798	APERION CARE	100.00%		(100,798)	36
37	V	19	DATA PROCESSING	7,060	APERION CARE	100.00%		(7,060)	37
38	V								38
39	Total			$ 384,211			$ 133,249	$ * (250,962)	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	APERION CONSULTING	100.00%	$ 7,524	$ 7,524	15
16	V	5	UTILITIES		APERION CONSULTING	100.00%			16
17	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	4,916	4,916	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	1,620	1,620	18
19	V	10	SALARY NURSE		APERION CONSULTING	100.00%	31,264	31,264	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	4,088	4,088	20
21	V	17	ADMINISTRATIVE		APERION CONSULTING	100.00%			21
22	V	19	PROFESSIONAL FEES		APERION CONSULTING	100.00%	734	734	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	1,257	1,257	23
24	V	21	CLERICAL & GENERAL		APERION CONSULTING	100.00%	1,320	1,320	24
25	V	24	SEMINARS		APERION CONSULTING	100.00%	256	256	25
26	V	25	AUTO AND TRAVEL		APERION CONSULTING	100.00%	2,939	2,939	26
27	V	26	INSURANCE		APERION CONSULTING	100.00%			27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	118	118	28
29	V	30	DEPRECIATION		APERION CONSULTING	100.00%	61	61	29
30	V	32	INTEREST		APERION CONSULTING	100.00%	18	18	30
31	V	33	REAL ESTATE TAX		APERION CONSULTING	100.00%			31
32	V	34	RENT		APERION CONSULTING	100.00%			32
33	V	35	AUTO LEASE		APERION CONSULTING	100.00%	441	441	33
34	V	10	CONSULTING	25,344	APERION CONSULTING	100.00%		(25,344)	34
35	V	01	DIETICIAN		APERION CONSULTING	100.00%			35
36	V	06	PAINTER		APERION CONSULTING	100.00%			36
37	V	06	PROJECT MANAGER	2,550	APERION CONSULTING	100.00%		(2,550)	37
38	V								38
39	Total			$ 27,894			$ 56,555	$ * 28,661	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE		APERION FINANCIAL	100.00%	16	$ 16	15
16	V	17	ADMINISTRATIVE		APERION FINANCIAL	100.00%	2,853	2,853	16
17	V	19	PROFESSIONAL FEES		APERION FINANCIAL	100.00%	812	812	17
18	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	49	49	18
19	V	21	CLERICAL & GENERAL		APERION FINANCIAL	100.00%	50,068	50,068	19
20	V	24	SEMINARS		APERION FINANCIAL	100.00%	94	94	20
21	V	25	AUTO AND TRAVEL		APERION FINANCIAL	100.00%	681	681	21
22	V	26	INSURANCE		APERION FINANCIAL	100.00%	7,111	7,111	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	321	321	23
24	V	19	HOME OFFICE EXPENSE	82,471	APERION FINANCIAL	100.00%		(82,471)	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			$ 82,471			$ 62,005	$ * (20,466)	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	8131 N. MONTICELLO, LLC	100.00%	$ 511	$ 511	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	755	755	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	172	172	17
18	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	11	11	18
19	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,011	1,011	19
20	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	2,028	2,028	20
21	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,554	1,554	21
22	V	34	RENT		8131 N. MONTICELLO, LLC	100.00%	547	547	22
23	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	572	572	23
24	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,986	1,986	24
25	V								25
26	V	34	RENT	12,000	8131 N. MONTICELLO, LLC	100.00%		(12,000)	26
27	V	34	RENT	283	8131 N. MONTICELLO, LLC	100.00%		(283)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,283			$ 9,147	$ * (3,136)	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PAYROLL SERVICES	$ 11,694	PROPAY HR LLC		$ 8,654	$ (3,040)	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			$ 11,694			$ 8,654	$ * (3,040)	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	39	THERAPY SERVICES	$ 21,894	RENEWAL REHAB		$ 18,741	$ (3,153)	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			$ 21,894			$ 18,741	$ * (3,153)	39

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YOSEF MEYSTEL TRUST	18.50%	Aperion Care Amboy	Amboy	1145 Frank St. LLC	Galesburg	Building Company	1
2	DAVID BERKOWITZ TRUST	24.50%	Aperion Care Jacksonville	Jacksonville	8131 N. MONTICELLO	Skokie	Home Office, Bldg Co	2
3	MICHAEL ROSEN	29.50%	Aperion Care International	Chicago	PROPAY	Evanston	Payroll Services	3
4	42170 LTD PARTNERSHIP	2.00%	Aperion Care Dolton	Dolton	RENEWAL REHAB	Skokie	Therapy Services	4
5	257 LTD PARTNERSHIP	2.00%	Riverwood Rehab	East Moline	APERION CARE, INC	Skokie	Corporate Manager	5
6	FREDRICK S. FRANKEL	1.00%	Apetion Care Bridgeport	Bridgeport	APERION CONSULTING, LLC	Skokie	Consulting Co.	6
7	STEVEN TUROFSKY	1.00%	Aperion Care Litchfield	Litchfield	APERION FINANCIAL, LLC	Skokie	Bookkeeping	7
8	MORRIS ESFORMES	3.00%	Aperion Care Springfield	Springfield	APERION ESTATES PERU	Peru, IN	ALF	8
9	DELECIA ESFORMES	3.00%	Aperion Care St. Elmo	St. Elmo	APERION CARE DEMOTTE	Demotte, IN	ALF	9
10	SYLVIA YOLINSKY	3.00%	Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	St. Louis, MO	ALF	10
11	JACK AND MARY YOLINSKY	3.00%	Aperion Care Burbank	Burbank	APERION CARE HIDDEN LAKE	St. Louis, MO	ILF	11
12	MGB MINING DEF BENEFIT PENSION UA 1/1/08	3.00%	Aperion Care Chicago Heights	Chicago Heights	APERION CARE HIDDEN LAKE	St. Louis, MO	Memory Care	12
13	HOWARD BORENSTEIN	4.50%	Aperion Care Forest Park	Forest Park	HEALTHCARE CONSTRUCTION	Chicago	Bldg Improvements	13
14	1219 LTD PARTNERSHIP	2.00%	Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care Plum Grove	Plum Grove				17
18			Aperion Care Evanston	Evanston				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Spring Valley	Spring Valley				20
21			Aperion Care Elgin	Elgin				21
22			Aperion Care Toluca	Toluca				22
23			Aperion Care Colfax	Colfax				23
24			Aperion Care Bloomington	Bloomington				24
25			The Arbors at Michigan City	Michigan City, IN				25
26			Aperion Care Demotte	Demotte,IN				26
27			Aperion Care Kokomo	Kokomo, IN				27
28			Aperion Care Tolleston Park	Gary, IN				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Peru	Peru, IN				30

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			Aperion Care Hidden Lake	St. Louis, MO				1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.40	3.50%	Alloc. Salary	$ 7,019	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.70	1.75%	Alloc. Salary	1,088	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.70	3.50%	Alloc. Salary	2,055	17-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.10	3.03%	Alloc. Salary	828	21-7	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.40	3.50%	Alloc. Salary	148	21-7	5
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.40	3.50%	Alloc. Salary	7,019	17-7	6
7	Fredrick Frankel	Owner	Administrative	1.50%	See Attached	1.40	3.50%	Alloc. Salary	5,134	17-7	7
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	1.40	3.50%	Alloc. Salary	5,080	17-7	8
9	Michael Rosen	Owner	Administrative	29.50%	See Attached	1.40	3.50%	Alloc. Salary	7,019	17-7	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	$ 35,390		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	925,063	39	$ 5,257	$	32,464	$ 184	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39	179		32,464	6	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	124,883	112,788	32,464	4,383	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	8,040		32,464	282	4
5	10	SALARY- NURSE	ACTUAL CENSUS	925,063	39	113,170	113,170	32,464	3,972	5
6	15	PAYROLL TAXES/GROUP INSU	ACTUAL CENSUS	925,063	39	8,067		32,464	283	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	1,588,216	1,274,084	32,464	55,737	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	316,131		32,464	11,094	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	52,521		32,464	1,843	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	899,005	810,120	32,464	31,550	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	126,855		32,464	4,452	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	150,166		32,464	5,270	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39	41,165		32,464	1,445	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	147,150		32,464	5,164	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	15,480		32,464	543	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	114,048		32,464	4,002	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			32,464		17
18	34	RENT	ACTUAL CENSUS	925,063	39	8,054		32,464	283	18
19	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	2,485		32,464	87	19
20	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	76,069		32,464	2,670	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,796,942	$ 2,310,162		$ 133,249	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	ACTUAL CENSUS	925,063	39	$ 214,389	$ 214,389	32,464	$ 7,524	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39			32,464		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	140,088	138,625	32,464	4,916	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	46,162		32,464	1,620	4
5	10	SALARY NURSE	ACTUAL CENSUS	925,063	39	890,856	890,856	32,464	31,264	5
6	15	PAYROLL TAXES/GROUP INSU	ACTUAL CENSUS	925,063	39	116,493		32,464	4,088	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39			32,464		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	20,901		32,464	734	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	35,826		32,464	1,257	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	37,620	25,723	32,464	1,320	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	7,289		32,464	256	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	83,735		32,464	2,939	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39			32,464		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	3,364		32,464	118	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	1,739		32,464	61	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	508		32,464	18	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			32,464		17
18	34	RENT	ACTUAL CENSUS	925,063	39			32,464		18
19	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	12,556		32,464	441	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,611,525	$ 1,269,593		$ 56,555	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	457		32,464	16	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	81,303	81,303	32,464	2,853	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	23,144		32,464	812	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	1,382		32,464	49	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	1,426,697	1,383,575	32,464	50,068	5
6	24	SEMINARS	ACTUAL CENSUS	925,063	39	2,672		32,464	94	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	19,412		32,464	681	7
8	26	INSURANCE	ACTUAL CENSUS	925,063	39	202,628		32,464	7,111	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	9,143		32,464	321	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					$ 1,766,837	$ 1,464,878		$ 62,005	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	925,063	39	$ 14,551	$	32,464	$ 511	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	21,508		32,464	755	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	4,910		32,464	172	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	320		32,464	11	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	925,063	39	28,813		32,464	1,011	5
6	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	57,774		32,464	2,028	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	925,063	39	44,281		32,464	1,554	7
8	34	RENT	ACTUAL CENSUS	925,063	39	15,600		32,464	547	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	16,285		32,464	572	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	925,063	39	56,595		32,464	1,986	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					$ 260,637	$		$ 9,147	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PAYROLL SERVICES	DIRECT			$	$		$ 8,654	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					$	$		$ 8,654	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY SERVICES	DIRECT			$	$		$ 18,741	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					$	$		$ 18,741	25

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	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	First Midwest Bank		X	Mortgage			$	$ 1,859,754			$ 53,293	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				839,799	12/11/15	3.6450	38,192	6
7	Auto Loan		X					26,192				7
8												8
9	TOTAL Facility Related						$	$ 2,725,745			$ 91,485	9
	B. Non-Facility Related*											
10	Interest - Insurance Policies		X								2,566	10
11	Interest Income		X								(3,900)	11
12	Interest Income - Bldg Co		X								(1)	12
13	See Supplemental Schedule										5,574	13
14	TOTAL Non-Facility Related						$	$			$ 4,239	14
15	TOTALS (line 9+line14)						$	$ 2,725,745			$ 95,724	15

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated from Aperion Care		X				$	$			$ 4,002	15
16	Allocated from Aperion Consulting		X								18	16
17	Allocated from 8131 N. Monticello LLC		X								1,554	17
18												18
19												19
20	TOTAL Non-Facility Related										5,574	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Crossing Rehab, Llc **#** 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 21,355	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.)		$ 27,280	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,925	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,309	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 31,234	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	38,411	8
	2011	38,955	9
	2012	23,782	10
	2013	24,740	11
	2014	25,294	12

2015 Accrual = $25,294 x 1.01 = $25,309

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Crossing Rehab, Llc COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-09-202-017	Long Term Care Facility	$ 25,293.68	$ 25,293.68
2.	10-23-325-045-0000	Home Office Allocation	$ 56,594.65	$ 1,991.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,888.33	$ 27,284.80

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Crossing Rehab, Llc COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2015	$ 233,306	1
2	Allocated from 8131 N. Monticello LLC			3,123	2
3	TOTALS			$ 236,429	3

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	108		2015	1972	$ 2,083,694	$ 44,459	35	$ 59,534	$ 15,075	$ 59,534	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
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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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)		38,497	2,116		1,334	(782)	7,082	68
69	Financial Statement Depreciation			70,160			(70,160)		69
70	TOTAL (lines 4 thru 69)		$ 2,122,191	$ 116,735		$ 60,868	$ (55,867)	$ 66,616	70

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,122,191	$ 116,735		$ 60,868	$ (55,867)	$ 66,616	1
2	Fire Sprinklers	2013	68,730		20	3,437	3,437	9,450	2
3	New White Alucabond Face Panel Mounted Sign	2014	4,141		20	276	276	414	3
4	Entrance Sign & 2 Formed Pan Faces	2014	5,450		20	1,090	1,090	2,180	4
5	100 Gallon Natural Gas Water Heater	2014	8,740		20	1,748	1,748	2,622	5
6	Security Camera System Installation	2014	13,842		20	2,768	2,768	3,922	6
7	Drain, Remove & Replace Old 100 Gallon Gas Tank	2014	5,168		20	258	258	366	7
8	New Landscape Design	2014	9,494		20	633	633	949	8
9	Vestibule-New Ceramic Tile & Walk Off Carpet Tile, Dumpster	2014	14,132		20	707	707	883	9
10	Lounge / Dining Room-New Vinyl Plankwood Tile, Wallcovering	2014	35,072		20	1,754	1,754	2,192	10
11	Admissions Office / Activiry Room-New Carpet Tile, Wallcovering	2014	4,620		20	231	231	289	11
12	Conference Room-New Carpet Tile, Wallcovering	2014	4,498		20	225	225	281	12
13	Therapy Room - Replace Carpet With Vinyl Tile, Wallcovering	2014	10,288		20	514	514	643	13
14	2 North Corridors - New Vct & Pure Vinyl Tile	2014	10,864		20	543	543	679	14
15	2 South Corridors - New Vct & Pure Vinyl Tile	2014	7,917		20	396	396	495	15
16	Corridors - Wallcovering, Handrails, Bumper & Corner Guards	2014	34,495		20	1,725	1,725	2,156	16
17	Nurse Call System Annunciator Panet	2014	5,956		20	298	298	323	17
18	10 Windows Near Egress	2015	4,841		20	141	141	141	18
19	B-Wing Corridor:Install Wallcovering & Paint	2015	17,689		20	884	884	884	19
20	Guest Bthrm:Replace Flr & Wall Tile, Toilet,Sink,Faucet,Fixture	2015	4,260		20	213	213	213	20
21	Nurses Station:2 Custom Nurse Station With Sink &Faucet	2015	28,376		20	1,419	1,419	1,419	21
22	Vestibule & Dining Rm:Wallcovering, New Divider Wall,Light Fix	2015	21,725		20	1,086	1,086	1,086	22
23	Therapy Rm: Laminate Workstation:Admissions Office-Shades	2015	9,970		20	498	498	498	23
24	Painting In:Library,Activity,Doorframes,Therapy,Dining Rm Ceil	2015	28,018		20	1,401	1,401	1,401	24
25	2 N Corridors & 2 S Corridors:Millwork Base,Sinage,Lighting	2015	43,324		20	2,166	2,166	2,166	25
26	Guest Bthrm & Vestibule:Tile,Mirror,Remove Windows	2015	2,561		20	128	128	128	26
27	Nurse Station:Demo,Electrical Power To New Station	2015	4,243		20	212	212	212	27
28	Library/Group & Conference Rm: Cove Base,Shades	2015	3,374		20	169	169	169	28
29	Lounge:New Vinyl Tile,Light Fixtures	2015	8,402		20	420	420	420	29
30	Therayp Rm & Misc:New Workstation, Dumpster	2015	5,563		20	278	278	278	30
31	Corridors:Re-Route Power And New Light Fixtures, 6 Outlets	2015	39,362		20	1,968	1,968	1,968	31
32	Fence	2015	4,340		20	217	217	217	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	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
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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)		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	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
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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)		$ 2,591,644	$ 116,735		$ 88,672	$ (28,063)	$ 105,662	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello LLC	2010	24,268	722	20	622	(100)	3,396	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello LLC	2010	10,871	1,292	20	544	(748)	3,010	9
10	Allocated from 8131 N. Monticello LLC	2013	1,891		20	95	95	284	10
11									11
12	Allocated from Aperion Care	2010	1,045	84	20	52	(32)	314	12
13	Allocated from Aperion Care	2012	296	11	20	15	4	59	13
14	Allocated from Aperion Care	2013	126	7	20	6	(1)	19	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)		$ 38,497	$ 2,116		$ 1,334	$ (782)	$ 7,082	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 38,497	$ 2,116		$ 1,334	$ (782)	$ 7,082	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 38,497	$ 2,116		$ 1,334	$ (782)	$ 7,082	34

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 32,286	$ 150	$ 6,368	$ 6,218	10	$ 10,038	71
72	Current Year Purchases	111,143	168	11,431	11,263	10	11,431	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 143,428	$ 318	$ 17,799	$ 17,481		$ 21,469	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 GMC SAVANA	2013	$ 54,662	$	$ 8,957	$ 8,957	5	$ 21,820	76
77		Allocated from Aperion Care	2015	1,106	146	221	75	5	370	77
78		Allocated from Aperion Consultir	2015	814	52	163	111	5	163	78
79										79
80	TOTALS			$ 56,582	$ 198	$ 9,341	$ 9,143		$ 22,353	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)	$	3,028,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	117,251	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	115,811	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(1,440)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	149,484	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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	Allocated from 8131 N. Monticello LLC				547			5
6								6
7	TOTAL				$ 547 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 6,679 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		$	$ 2,670	17
18	Allocated from Aperion Consulting			441	18
19					19
20					20
21	TOTAL		$	$ 3,111	21

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs		$		$ 158,269	$		$ 158,269	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				5,734			5,734	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				137,543			137,543	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 03	# of prescrpts				44,782			44,782	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						16,796	839		17,635	13
14	TOTAL				$		$ 363,124	$ 839		$ 363,963	14

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

STATE OF ILLINOIS

Facility Name & ID Number River Crossing Rehab, Llc **#** 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 750	$ 750	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,574,399	1,574,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,792	74,792	6
7	Other Prepaid Expenses	894	894	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(27,742)	60,181	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,623,093	$ 1,711,016	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		233,306	13
14	Buildings, at Historical Cost		2,083,694	14
15	Leasehold Improvements, at Historical Cost	329,399	329,399	15
16	Equipment, at Historical Cost	145,688	228,688	16
17	Accumulated Depreciation (book methods)	(96,573)	(141,032)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,706)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	875,456	482,345	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,253,970	$ 3,209,694	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,877,063	$ 4,920,710	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 517,834	$ 524,200	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	865,991	865,991	29
30	Accrued Salaries Payable	117,923	117,923	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,889	3,889	31
32	Accrued Real Estate Taxes(Sch.IX-B)		25,309	32
33	Accrued Interest Payable	(479)	7,222	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	37,779	60,138	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,542,937	$ 1,604,672	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,859,754	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	770,500	770,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 770,500	$ 2,630,254	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,313,437	$ 4,234,926	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 563,626	$ 685,784	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,877,063	$ 4,920,710	48

***(See instructions.)**

Facility Name & ID Number River Crossing Rehab, Llc **#** 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (67,743)	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt**	50,000	3
4	**Prior Year Social Worker**	(3,307)	4
5	**Rounding**	(4)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (21,054)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	626,347	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) **Members Distribution**	(41,667)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 584,680	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)**	$ 563,626	24 *

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,431,920	1
2	Discounts and Allowances for all Levels	1,444,242	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,876,162	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,545	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 226,545	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	15,066	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	823	19
20	Radiology and X-Ray	452	20
21	Other Medical Services	1,768	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,109	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,900	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,900	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,155	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,155	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,125,871	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	787,027	31
32	Health Care	1,938,093	32
33	General Administration	1,584,737	33
	B. Capital Expense		
34	Ownership	555,797	34
	C. Ancillary Expense		
35	Special Cost Centers	400,867	35
36	Provider Participation Fee	233,003	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,499,524	40
41	**Income before Income Taxes (line 30 minus line 40)****	626,347	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 626,347	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,955,536	44
45	Private Pay - Net Inpatient Revenue	82,540	45
46	Medicare - Net Inpatient Revenue	474,455	46
47	Other-(specify) Insurance	363,631	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,876,162	49

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

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

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

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,225	2,060	$ 73,095	$ 35.48	1
2	Assistant Director of Nursing	1,064	1,120	27,544	24.59	2
3	Registered Nurses	7,401	7,968	171,801	21.56	3
4	Licensed Practical Nurses	22,072	23,322	424,024	18.18	4
5	CNAs & Orderlies	45,252	47,358	484,222	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,076	11,094	219,739	19.81	8
9	Activity Director					9
10	Activity Assistants	2,927	3,123	32,463	10.39	10
11	Social Service Workers	7,283	7,994	147,395	18.44	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	23,365	11.23	13
14	Head Cook	268	282	2,355	8.35	14
15	Cook Helpers/Assistants	9,129	9,447	85,752	9.08	15
16	Dishwashers					16
17	Maintenance Workers	4,904	5,280	65,482	12.40	17
18	Housekeepers	10,972	11,440	107,367	9.39	18
19	Laundry	4,705	5,074	43,228	8.52	19
20	Administrator	2,008	2,080	71,089	34.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,880	2,240	35,690	15.93	23
24	Clerical	534	549	6,181	11.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,073	2,195	25,285	11.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,733	144,706	$ 2,046,077 *	$ 14.14	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	275	$ 17,531	01-03	35
36	Medical Director	Monthly	24,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	303	25,344	10-03	38
39	Pharmacist Consultant	Monthly	9,918	10-03	39
40	Physical Therapy Consultant	Per Visit	650	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	748	11-03	44
45	Social Service Consultant	40	2,503	12-03	45
46	Other(specify) Psychiatric MD	67	4,500	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	704	$ 85,944		49

C. CONTRACT NURSES

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

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Paxton	Administrator	0.00%	$ 71,089
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,089

B. Administrative - Other

Description	Amount
Aperion Care- Management Fees	$ 276,353
TOTAL (agree to Schedule V, line 17, col. 3)	$ 276,353
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 22,810
Aperion Care Inc.	Home Office Expense	100,798
Aperion Financial	Home Office Expense	82,471
ProPay HR	Payroll Processing	11,694
See Attached	Legal	2,244
Pendulum LLC	Risk Management	1,184
Eli Oelbaum	HUD Audit	6,500
Personnel Planners	Unemployment Tax Consult	755
Aperion Care Inc.	Data Processing	7,060
Creative Technology Solutions	Data Processing	6,473
E-Health Data Solutions	Data Processing	4,500
See Supplemental Schedule		29,865
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 276,354

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,945
Unemployment Compensation Insurance	47,211
FICA Taxes	147,500
Employee Health Insurance	39,677
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	665
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,998

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	2,230
Health Care Worker Background Check	2,896
(Indicate # of checks performed 290)	
Patient Background Checks	
Dues and Subscriptions	17,724
License and Permits	616
Allocated from Aperion Care	1,843
Allocated from Aperion Consulting	1,257
See Supplemental Schedule	60
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,626

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	572
Allocated from Aperion Care	4,452
Allocated from Aperion Consulting	256
See Supplemental Schedule	94
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,374

**See instructions.

Facility Name & ID Number River Crossing Rehab, Llc # 0052761 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number River Crossing Rehab, Llc **#** 0052761 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $19,131**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,529** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **233,003**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,137**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.