

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0052175</u></p> <p>Facility Name: <u>Rivershores Healthcare And Rehabilitation Centre, Llc</u></p> <p>Address: <u>578 West Commercial St</u> <u>Marseilles</u> <u>61341</u> Number City Zip Code</p> <p>County: <u>Lasalle</u></p> <p>Telephone Number: <u>(815) 795-5121</u> Fax # <u>(815) 795-6213</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/2013</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/15</u> to <u>12/31/15</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>							

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc

0052175 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,595</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>103</u>	TOTALS	<u>103</u>	<u>37,595</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>22,278</u>	<u>2,502</u>	<u>4,509</u>	<u>29,289</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>22,278</u>	<u>2,502</u>	<u>4,509</u>	<u>29,289</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.91%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 103 and days of care provided 3,305

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation C # 0052175 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	203,893	40,929	8,045	252,867		252,867	35	252,902		1
2	Food Purchase		157,490		157,490		157,490	(4,516)	152,974		2
3	Housekeeping	47,156	17,967	68,711	133,834		133,834	684	134,518		3
4	Laundry	20,403	6,886	45,807	73,096		73,096		73,096		4
5	Heat and Other Utilities			103,480	103,480		103,480	1,416	104,896		5
6	Maintenance	53,046	17,900	87,483	158,429		158,429	7,677	166,106		6
7	Other (specify):*										7
8	TOTAL General Services	324,498	241,172	313,526	879,196		879,196	5,296	884,492		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	187	12,187		9
10	Nursing and Medical Records	1,730,505	114,996	77,347	1,922,848		1,922,848	16,381	1,939,229		10
10a	Therapy	70,546		1,540	72,086		72,086		72,086		10a
11	Activities	121,608	11,311	832	133,751		133,751	6	133,757		11
12	Social Services	64,954			64,954		64,954	3,358	68,312		12
13	CNA Training										13
14	Program Transportation			3,470	3,470		3,470		3,470		14
15	Other (specify):*							5,457	5,457		15
16	TOTAL Health Care and Programs	1,987,613	126,307	95,189	2,209,109		2,209,109	25,389	2,234,498		16
	C. General Administration										
17	Administrative	76,224		81,899	158,123		158,123	(65,261)	92,862		17
18	Directors Fees										18
19	Professional Services			197,182	197,182		197,182	(111,499)	85,683		19
20	Dues, Fees, Subscriptions & Promotions			96,612	96,612		96,612	(37,252)	59,360		20
21	Clerical & General Office Expenses	120,110	27,990	410,096	558,196		558,196	(229,590)	328,606		21
22	Employee Benefits & Payroll Taxes			400,201	400,201		400,201	(63)	400,138		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,362	8,362		8,362	33	8,395		24
25	Other Admin. Staff Transportation			13,537	13,537		13,537	(505)	13,032		25
26	Insurance-Prop.Liab.Malpractice			62,473	62,473		62,473	376	62,849		26
27	Other (specify):*							30,958	30,958		27
28	TOTAL General Administration	196,334	27,990	1,270,362	1,494,686		1,494,686	(412,803)	1,081,883		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,508,445	395,469	1,679,077	4,582,991		4,582,991	(382,118)	4,200,873		29

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc #0052175 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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			37,063	37,063		37,063	96,181	133,244			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,797	2,797		2,797	(2,797)	0			32
33	Real Estate Taxes			49,236	49,236		49,236	2,648	51,884			33
34	Rent-Facility & Grounds			533,331	533,331		533,331	(533,331)	0			34
35	Rent-Equipment & Vehicles			11,642	11,642		11,642	409	12,051			35
36	Other (specify):*											36
37	TOTAL Ownership			634,069	634,069		634,069	(436,890)	197,179			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,459	582,571	747,030		747,030		747,030			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			213,339	213,339		213,339		213,339			42
43	Other (specify):*	13,699		18,540	32,239		32,239	(32,239)	0			43
44	TOTAL Special Cost Centers	13,699	164,459	814,450	992,608		992,608	(32,239)	960,369			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,522,144	559,928	3,127,596	6,209,668		6,209,668	(851,246)	5,358,422			45

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

Rivershores Healthcare And Rehabilitation Centre, Llc

ID# 0052175

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (1,918)	02	1
2	Misc. Income	(5,096)	21	2
3	Marketing Consultant	(18,540)	43	3
4	Bank Charges	(7,247)	21	4
5	Marketing Salaries	(13,699)	43	5
6	Theft & Loss	(4,582)	21	6
7	Sequestration Expense	(26,720)	21	7
8	Marketing Travel	(2,343)	25	8
9	Chambers of Commerce	(250)	20	9
10	Non-Allowable Legal	(4,854)	19	10
11	Capitalized R&M	(3,087)	06	11
12	Additional R&M	3,384	06	12
13	Jury Duty	(72)	10	13
14	Medical Records Revenue	(147)	10	14
15	Prior Period Expense	(63)	22	15
16	Non-Allowable Interest Expense	(2,797)	32	16
17	Rent for Sale Leaseback Arrangement	(533,331)	34	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	(621,361)		49

Rivershores Healthcare And Rehabilitation Centre, Llc

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 Rivershores Healthcare And Rehabilitation Centre, Llc# 0052175

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			35									35	1
2	Food Purchase	(4,516)											(4,516)	2
3	Housekeeping			678	6								684	3
4	Laundry													4
5	Heat and Other Utilities			1,203	213								1,416	5
6	Maintenance	297		7,071	309								7,677	6
7	Other (specify):*													7
8	TOTAL General Services	(4,219)		8,987	528								5,296	8
	B. Health Care and Programs													
9	Medical Director			187									187	9
10	Nursing and Medical Records	(219)		16,600									16,381	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services			3,358									3,358	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,457									5,457	15
16	TOTAL Health Care and Programs	(219)		25,608									25,389	16
	C. General Administration													
17	Administrative			16,638		(81,899)							(65,261)	17
18	Directors Fees													18
19	Professional Services	(4,854)		(106,998)	74	279							(111,499)	19
20	Fees, Subscriptions & Promotions	(40,154)		2,898	4								(37,252)	20
21	Clerical & General Office Expenses	(319,879)		90,247	42								(229,590)	21
22	Employee Benefits & Payroll Taxes	(63)											(63)	22
23	Inservice Training & Education													23
24	Travel and Seminar			33									33	24
25	Other Admin. Staff Transportation	(2,343)		257		1,582							(505)	25
26	Insurance-Prop.Liab.Malpractice			237	139								376	26
27	Other (specify):*			30,958									30,958	27
28	TOTAL General Administration	(367,292)		34,269	259	(80,038)							(412,803)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(371,730)		68,864	787	(80,038)							(382,118)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc

0052175

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	90,682		4,083	1,416								96,181	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,620)			2,823								(2,797)	32
33	Real Estate Taxes				2,648								2,648	33
34	Rent-Facility & Grounds	(533,331)		5,997	(5,997)								(533,331)	34
35	Rent-Equipment & Vehicles			409									409	35
36	Other (specify):*													36
37	TOTAL Ownership	(448,269)		10,489	890								(436,890)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(32,239)											(32,239)	43
44	TOTAL Special Cost Centers	(32,239)											(32,239)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(852,237)		79,353	1,677	(80,038)							(851,246)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>DIETARY</u>	\$	<u>MOSAIC HEALTHCARE</u>	100.00%	\$ 35	\$	35	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	678		678	16
17	V	5 <u>UTILITIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	1,203		1,203	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	7,071		7,071	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	187		187	19
20	V	10 <u>NURSING SALARIES</u>	18,540	<u>MOSAIC HEALTHCARE</u>	100.00%	35,140		16,600	20
21	V	11 <u>ACTIVITIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	6		6	21
22	V	12 <u>SOCIAL SERVICE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	3,358		3,358	22
23	V	15 <u>NURSING EMP BENS & PR TAXES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	5,457		5,457	23
24	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	16,638		16,638	24
25	V	19 <u>PROFESSIONAL FEES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	(1,938)		(1,938)	25
26	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	2,898		2,898	26
27	V	21 <u>CLERICAL AND GENERAL SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	109,465		109,465	27
28	V	21 <u>CLERICAL AND GENERAL EXP</u>	30,900	<u>MOSAIC HEALTHCARE</u>	100.00%	11,683		(19,217)	28
29	V	24 <u>SEMINARS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	33		33	29
30	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	257		257	30
31	V	26 <u>INSURANCE</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	237		237	31
32	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	30,958		30,958	32
33	V	30 <u>DEPRECIATION</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	4,083		4,083	33
34	V	32 <u>INTEREST EXPENSE</u>		<u>MOSAIC HEALTHCARE</u>	100.00%				34
35	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	5,997		5,997	35
36	V	35 <u>EQUIPMENT RENTAL</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	409		409	36
37	V	19 <u>BOOKKEEPING</u>	86,520	<u>MOSAIC HEALTHCARE</u>	100.00%			(86,520)	37
38	V	19 <u>ADMINISTRATIVE CONSULTANT</u>	18,540	<u>MOSAIC HEALTHCARE</u>	100.00%			(18,540)	38
39	Total		\$ 154,500			\$ 233,853	\$ *	79,353	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSKEEPING	\$	4600 TOUHY, LLC	100.00%	\$ 6	\$	6	15
16	V	5 UTILITIES		4600 TOUHY, LLC	100.00%	213		213	16
17	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	309		309	17
18	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	74		74	18
19	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	4		4	19
20	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	42		42	20
21	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	139		139	21
22	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	1,416		1,416	22
23	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,823		2,823	23
24	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,648		2,648	24
25	V								25
26	V	34 RENT	5,997	4600 TOUHY, LLC	100.00%			(5,997)	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		\$ 5,997			\$ 7,674	\$ *	1,677	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	279	\$	279	15	
16	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	1,582		1,582	16	
17	V								17	
18	V	17 MANAGEMENT FEES	81,899	TETRAD MANAGEMENT, LLC	100.00%			(81,899)	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		\$ 81,899				\$	1,861	\$ * (80,038)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation # 0052175 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	491,775	10	\$ 583	\$ 29,289	\$ 35	1	
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376	29,289	678	2	
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206	29,289	1,203	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728	29,289	7,071	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145	29,289	187	5	
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	29,289	35,140	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95	29,289	6	7	
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	29,289	3,358	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625	29,289	5,457	9	
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	29,289	16,638	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)	29,289	(1,938)	11	
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662	29,289	2,898	12	
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	491,775	10	1,837,959	1,837,959	29,289	109,465	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155	29,289	11,683	14	
15	24	SEMINARS	PATIENT DAYS	491,775	10	556	29,289	33	15	
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308	29,289	257	16	
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971	29,289	237	17	
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798	29,289	30,958	18	
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552	29,289	4,083	19	
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10		29,289		20	
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700	29,289	5,997	21	
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863	29,289	409	22	
23									23	
24									24	
25	TOTALS					\$ 3,926,495	\$ 2,763,717	\$ 233,853	25	

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS 491,775	10	\$ 107	\$	29,289	\$ 6	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 491,775	10	3,569		29,289	213	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 491,775	10	5,190		29,289	309	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 491,775	10	1,250		29,289	74	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 491,775	10	63		29,289	4	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 491,775	10	698		29,289	42	6
7	26	INSURANCE	MNGCR. PATIENT DAYS 491,775	10	2,336		29,289	139	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS 491,775	10	23,779		29,289	1,416	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 491,775	10	47,406		29,289	2,823	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 491,775	10	44,453		29,289	2,648	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				\$ 128,850	\$		\$ 7,674	25

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 TETRAD MANAGEMENT, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682	29,289	279	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559	29,289	1,582	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					\$ 31,241	\$	\$ 1,861	25

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

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

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Allocated from 4600 Touhy LLC	X								2,823	6									
7											7									
8											8									
9	TOTAL Facility Related									2,823	9									
B. Non-Facility Related*																				
10	Interest Income	X								(2,823)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related									(2,823)	14									
15	TOTALS (line 9+line14)									(0)	15									

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

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

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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
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										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	48,265		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	50,918		2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,653		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	49,231		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.		\$	51,884		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	_____			8
	2011	_____			9
	2012	46,678			10
	2013	48,642			11
	2014	48,271			12
2015 Accrual = \$48,271 x 1.02 = \$49,231 (Rounded)					
Allocated from 4600 Touhy, LLC \$2,648					
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 Rivershores Healthcare And Rehabilitation Centre, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-49-325-027</u>	<u>Long Term Care Property</u>	\$ <u>47,616.72</u>	\$ <u>47,616.72</u>
2. <u>15-49-325-026</u>	<u>Long Term Care Property</u>	\$ <u>653.86</u>	\$ <u>653.86</u>
3. <u>See Attached</u>	<u>See Attached</u>	\$ <u>86,316.15</u>	\$ <u>2,570.40</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>134,586.73</u>	\$ <u>50,840.98</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Rivershores Healthcare And Rehabilitation Centre, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2013</u>	<u>\$ 217,814</u>	<u>1</u>
2				<u>5,360</u>	<u>2</u>
3	TOTALS			\$ 223,174	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	103		2013	1967	\$ 1,765,573	\$	39	\$ 45,271	\$ 45,271	\$ 135,813	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc

0052175

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		62,440	1,796		2,613	817	10,137	68
69			37,063			(37,063)		69
70		\$ 1,828,013	\$ 38,859		\$ 47,884	\$ 9,025	\$ 145,950	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,828,013	\$ 38,859		\$ 47,884	\$ 9,025	\$ 145,950	1
2	Water Boiler	2013	6,725		20	336	336	925	2
3	Water Heater	2013	9,400		20	470	470	1,136	3
4	Water Heater Repair	2013	3,011		20	151	151	427	4
5	Generator Repair	2013	2,611		20	131	131	381	5
6	Wiring For Telecom	2014	7,176		20	1,025	1,025	1,538	6
7	Piping	2014	3,391		20	170	170	325	7
8	Piping	2014	3,026		20	151	151	303	8
9	New Rooftop A/C Unit	2014	3,020		20	151	151	239	9
10	Flooring For Patio & Resident Room	2014	6,737		20	363	363	423	10
11	Signage	2014	6,858		20	343	343	572	11
12	Upgrade Code Alert System	2015	6,684		20	1,337	1,337	1,337	12
13	Fire Alarm - Replace Annunciator At North Nurses Station	2015	3,087		20	154	154	154	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708	34

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

Facility Name & ID Number **Rivershores Healthcare And Rehabilitation Centre, Llc**

0052175

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708	34

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

Facility Name & ID Number **Rivershores Healthcare And Rehabilitation Centre, Llc**

0052175

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
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21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 1,889,739	\$ 38,859		\$ 52,665	\$ 13,807	\$ 153,708

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	30,580	784	35	1,019	235	4,077	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	513	99	20	26	(73)	77	9
10	Allocated from Mosaic Healthcare	2012	6,385	281	20	319	38	1,277	10
11									11
12	Allocated from 4600 Touhy LLC	2012	19,694	507	20	985	478	3,939	12
13	Allocated from 4600 Touhy LLC	2013	4,792	113	20	240	127	719	13
14	Allocated from 4600 Touhy LLC	2014	476	12	20	24	12	48	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)		\$ 62,440	\$ 1,796		\$ 2,613	\$ 817	\$ 10,137	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 62,440	\$ 1,796		\$ 2,613	\$ 817	\$ 10,137
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 62,440	\$ 1,796		\$ 2,613	\$ 817	\$ 10,137

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 736,169	\$ 3,502	\$ 77,885	\$ 74,383	10	\$ 223,577	71
72	Current Year Purchases	16,816		2,694	2,694	10	2,694	72
73	Fully Depreciated Assets	14,885				10	14,885	73
74								74
75	TOTALS	\$ 767,870	\$ 3,502	\$ 80,579	\$ 77,077		\$ 241,156	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic HC	2015	\$ 5,658	\$ 201	\$	\$ (201)	5	\$ 5,658	76
77										77
78										78
79										79
80	TOTALS			\$ 5,658	\$ 201	\$	\$ (201)		\$ 5,658	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,886,441	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,562	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 133,244	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 90,682	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 400,522	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)

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:		103		\$ 533,331			3
4	Additions							4
5					(533,331)			5
6								6
7	TOTAL		103		\$			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: _____ *

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: \$ 1,731 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Champion	\$	\$ 10,319	17
18		Challenger Bus			18
19					19
20					20
21	TOTAL		\$	\$ 10,319	21

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 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 183,501	\$		\$ 183,501	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,663			81,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			270,075			270,075	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				152,476		152,476	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					47,332	11,983		59,315	13
14	TOTAL			\$		\$ 582,571	\$ 164,459		\$ 747,030	14

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

Facility Name & ID Number **Rivershores Healthcare And Rehabilitation Centre, Llc** # **0052175**

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 235	\$	1
2	Cash-Patient Deposits	11,637		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,386,369		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,253		6
7	Other Prepaid Expenses	9,370		7
8	Accounts Receivable (owners or related parties)	485,419		8
9	Other(specify):	53,227		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,958,510	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	40,966		15
16	Equipment, at Historical Cost	133,693		16
17	Accumulated Depreciation (book methods)	(60,275)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	296,740		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 411,124	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,369,634	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 945,304	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,637		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,869		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,231		32
33	Accrued Interest Payable	1,612		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	1,419,228		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,559,216	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,559,216	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (189,582)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,369,634	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 473,279	1
2	Restatements (describe):		2
3	Depreciation	(11,105)	3
4	Loss on Intercompany Loan	6,859	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 469,033	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(658,615)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (658,615)	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)	\$ (189,582)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, # 0052175 Report Period Beginning: 01/01/15Ending: 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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,690,686	1
2	Discounts and Allowances for all Levels	(1,512,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,178,063	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,149,960	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,149,960	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	2,464	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	172,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,499	19
20	Radiology and X-Ray	4,637	20
21	Other Medical Services	5,709	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 202,992	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,918	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,918	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,120	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,120	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,551,053	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	879,196	31
32	Health Care	2,209,109	32
33	General Administration	1,494,686	33
B. Capital Expense			
34	Ownership	634,069	34
C. Ancillary Expense			
35	Special Cost Centers	779,269	35
36	Provider Participation Fee	213,339	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,209,668	40
41	Income before Income Taxes (line 30 minus line 40)**	(658,615)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (658,615)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,847,407	44
45	Private Pay - Net Inpatient Revenue	485,058	45
46	Medicare - Net Inpatient Revenue	697,863	46
47	Other-(specify) <u>Hospice</u>	99,829	47
48	Other-(specify) <u>Insurance</u>	47,906	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,178,063	49

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

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

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

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

Facility Name & ID Number **Rivershores Healthcare And Rehabilitation Centre, Llc**

0052175

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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,120	2,160	\$ 71,046	\$ 32.89	1
2	Assistant Director of Nursing	2,608	2,648	80,139	30.26	2
3	Registered Nurses	15,986	17,067	486,393	28.50	3
4	Licensed Practical Nurses	12,600	13,461	340,440	25.29	4
5	CNAs & Orderlies	52,769	58,530	726,611	12.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,984	2,140	70,546	32.97	8
9	Activity Director	2,008	2,190	48,080	21.95	9
10	Activity Assistants	6,673	7,292	64,391	8.83	10
11	Social Service Workers	3,906	4,088	64,954	15.89	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,210	31,542	14.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,896	17,117	172,351	10.07	15
16	Dishwashers					16
17	Maintenance Workers	3,067	3,415	53,046	15.53	17
18	Housekeepers	5,099	5,554	47,156	8.49	18
19	Laundry	2,035	2,230	20,403	9.15	19
20	Administrator	1,904	2,006	76,224	38.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,100	8,872	120,110	13.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,937	2,086	25,876	12.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,760	1,760	22,837	12.98	33
34	TOTAL (lines 1 - 33)	142,484	154,826	\$ 2,522,145 *	\$ 16.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,045	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Quarterly	1,590	10-03	37
38	Nurse Consultant	Monthly	12,360	10-03	38
39	Pharmacist Consultant	Monthly	7,674	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	832	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Renal Therapy Consultant</u>	Monthly	1,540	10a-03	47
48	<u>MDS Consultant</u>	Monthly	18,540	10-03	48
49	TOTAL (lines 35 - 48)		\$ 62,581		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,487	37,183	10-03	52
53	TOTAL (lines 50 - 52)	1,487	\$ 37,183		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tina McCoy	Administrator	0	\$ 36,623	Workers' Compensation Insurance	\$ 58,310	IDPH License Fee	\$	
Anna Johnson	Administrator	0	39,601	Unemployment Compensation Insurance	54,861	Advertising: Employee Recruitment	36,911	
				FICA Taxes	189,244	Health Care Worker Background Check (Indicate # of checks performed _____)	4,628	
				Employee Health Insurance	57,520	Patient Background Checks		
				Employee Meals		Licenses & Permits	2,687	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,232	
				Safe Harbor Match Expense	11,754	Allocated from Mosaic HC	2,898	
				Other Employee Benefits	28,449	Allocated from 4600 Touhy LLC	4	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 76,224					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
Tetrad Management - Management Fees	\$ 81,899						Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	8,362
			\$ 81,899				Allocated from Mosaic HC	33
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type	Amount						
FR&R/Marcum LLP	Accounting	\$ 18,780		\$				
Personnel Planners	Unemployment Consultant	4,790						
See Attached	Legal	27,060						
Mosaic Healthcare	Bookkeeping	86,520						
Smartlinks	Workforce Management	4,138						
Ability	Billing Software	4,742						
Provinet Solutions	IT Consulting	550						
Health Medex	EMR Software	19,910						
Galaxy	Clinical & Financial Software	1,672						
eHealth Data Solutions	MDS Software	4,200						
Mosaic Healthcare	Administrative Consulting	18,540						
See Supplemental Schedule		6,281						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL	
			\$ 197,182	\$			\$ 8,395	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc# 0052175

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$10,373
- (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? Yes
- (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. \$ 17,132 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 12/31/2014
- (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. \$ 213,339
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.