FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0052795

Facility Name: River View Rehab Center

Address: 50 North Jane (Number) Elgin (City) 60123 (Zip Code)

County: Kane

Telephone Number: (847) 697-3750 **Fax #** (847) 697-5385

HFS ID Number:

Date of Initial License for Current Owners: 6/1/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	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	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	59,764	1,592	5,037	66,393	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,764	1,592	5,037	66,393	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.36%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 3,288

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	295,460	48,690	18,171	362,321		362,321		362,321			1
2	Food Purchase		311,541		311,541		311,541	1,856	313,397			2
3	Housekeeping	228,955	33,124		262,079		262,079	2,274	264,353			3
4	Laundry	75,808	22,533		98,341		98,341		98,341			4
5	Heat and Other Utilities			184,089	184,089		184,089	(18,867)	165,222			5
6	Maintenance	33,453	1,304	81,795	116,552		116,552	7,221	123,773			6
7	Other (specify):*											7
8	TOTAL General Services	633,676	417,192	284,055	1,334,923		1,334,923	(7,516)	1,327,407			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,506,740	46,056	199,327	2,752,123		2,752,123	(24,262)	2,727,861			10
10a	Therapy	80,156			80,156		80,156		80,156			10a
11	Activities	104,019	10,117	2,512	116,648		116,648		116,648			11
12	Social Services	254,050	1,817	2,008	257,875		257,875		257,875			12
13	CNA Training											13
14	Program Transportation			34,357	34,357		34,357		34,357			14
15	Other (specify):*							16,582	16,582			15
16	TOTAL Health Care and Programs	2,944,965	57,990	252,604	3,255,559		3,255,559	(7,680)	3,247,879			16
	C. General Administration											
17	Administrative	113,930		655,200	769,130		769,130	(619,117)	150,013			17
18	Directors Fees											18
19	Professional Services			99,885	99,885	(180)	99,705	11,024	110,729			19
20	Dues, Fees, Subscriptions & Promotions			49,949	49,949		49,949	(6,478)	43,471			20
21	Clerical & General Office Expenses	157,957		344,315	502,272		502,272	(137,080)	365,192			21
22	Employee Benefits & Payroll Taxes			494,013	494,013		494,013		494,013			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,464	1,464		1,464	1,925	3,389			24
25	Other Admin. Staff Transportation			4,904	4,904		4,904	6,952	11,856			25
26	Insurance-Prop.Liab.Malpractice			235,052	235,052		235,052	1,413	236,465			26
27	Other (specify):*							41,124	41,124			27
28	TOTAL General Administration	271,887		1,884,782	2,156,669	(180)	2,156,489	(700,238)	1,456,251			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,850,528	475,182	2,421,441	6,747,151	(180)	6,746,971	(715,434)	6,031,537			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number River View Rehab Center #0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,492	15,492		15,492	270	15,762			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,143	2,143		2,143	828	2,971			32
33	Real Estate Taxes			117,460	117,460	180	117,640	6,009	123,649			33
34	Rent-Facility & Grounds			1,088,270	1,088,270		1,088,270	10,115	1,098,385			34
35	Rent-Equipment & Vehicles			495	495		495		495			35
36	Other (specify):*											36
37	TOTAL Ownership			1,223,860	1,223,860	180	1,224,040	17,222	1,241,263			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,425	762,398	969,823		969,823		969,823			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			501,037	501,037		501,037		501,037			42
43	Other (specify):*			40,226	40,226		40,226	(40,226)				43
44	TOTAL Special Cost Centers		207,425	1,303,661	1,511,086		1,511,086	(40,226)	1,470,860			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,850,528	682,607	4,948,962	9,482,097		9,482,097	(738,437)	8,743,660			45

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(20,449)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,921)	30		9
10	Interest and Other Investment Income	(1,964)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,058)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,820)	21		24
25	Fund Raising, Advertising and Promotional	(2,919)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(234,109)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (339,315)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(399,122)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (399,122)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (738,437)		37

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

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

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

River View Rehab Center

ID# 0052795

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (21,961)	21	1
2	Vending Income	(1,000)	02	2
3	Marketing Expense	(4,355)	43	3
4	Bank Charges	(7,739)	21	4
5	Medical Record Income and Reimbursement	(795)	10	5
6	PAC Dues	(6,491)	20	6
7	Non Allowable PY Adjustments	(189,137)	21	7
8	Misc Income	(2,631)	21	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				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**	(234,109)		49

River View Rehab Center

ID# 0052795

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River View Rehab Center **#** 0052795 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,075)		2,660		271							1,856	2
3	Housekeeping			2,274									2,274	3
4	Laundry													4
5	Heat and Other Utilities	(20,449)		1,582									(18,867)	5
6	Maintenance			7,150		71							7,221	6
7	Other (specify):*													7
8	**TOTAL General Services**	(21,524)		13,666		342							(7,516)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(795)				(23,467)							(24,262)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					16,582							16,582	15
16	**TOTAL Health Care and Programs**	(795)				(6,885)							(7,680)	16
	C. General Administration													
17	Administrative			(619,117)									(619,117)	17
18	Directors Fees													18
19	Professional Services			1,844	487	8,693							11,024	19
20	Fees, Subscriptions & Promotions	(9,410)		2,839	38	55							(6,478)	20
21	Clerical & General Office Expenses	(294,346)		187,208		(29,942)							(137,080)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			865		1,060							1,925	24
25	Other Admin. Staff Transportation					6,952							6,952	25
26	Insurance-Prop.Liab.Malpractice			1,413									1,413	26
27	Other (specify):*			38,987		2,137							41,124	27
28	**TOTAL General Administration**	(303,756)		(385,961)	524	(11,045)							(700,238)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(326,075)		(372,295)	524	(17,588)							(715,434)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River View Rehab Center # 0052795 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,921)		3,077	4,115								270	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,964)			2,792								828	32
33	Real Estate Taxes				6,009								6,009	33
34	Rent-Facility & Grounds			22,133	(12,018)								10,115	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(8,885)		25,209	898								17,222	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):*	(4,355)				(35,871)							(40,226)	43
44	**TOTAL Special Cost Centers**	(4,355)				(35,871)							(40,226)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(339,315)		(347,086)	1,423	(53,459)							(738,437)	45

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	$ 2,660	$ 2,660	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,274	2,274	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,582	1,582	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	7,150	7,150	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	18,177	18,177	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	17,906	17,906	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,844	1,844	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,839	2,839	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,375	10,375	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	176,833	176,833	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	865	865	25
26	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,413	1,413	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	38,987	38,987	27
28	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,077	3,077	28
29	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	22,133	22,133	29
30	V								30
31	V	17	MANAGEMENT FEES	655,200	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(655,200)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 655,200			$ 308,114	$ * (347,086)	39

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	487	$ 487	15
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	38	38	16
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	4,115	4,115	17
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,792	2,792	18
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	6,009	6,009	19
20	V								20
21	V	34	RENT	12,018	PREMIER HC REAL ESTATE, LLC	100.00%		(12,018)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,018			$ 13,441	$ * 1,423	39

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	iCare Consulting Services LLC	100.00%	$ 271	$ 271	15
16	V	6	REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	71	71	16
17	V	10	NURSING SALARIES	182,037	iCare Consulting Services LLC	100.00%	158,570	(23,467)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	16,582	16,582	18
19	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	8,693	8,693	19
20	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	55	55	20
21	V	21	CLERICAL AND GENERAL	56,578	iCare Consulting Services LLC	100.00%	6,870	(49,708)	21
22	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	19,766	19,766	22
23	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	1,060	1,060	23
24	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	2,137	2,137	24
25	V	25	AUTO & TRAVEL		iCare Consulting Services LLC	100.00%	6,952	6,952	25
26	V								26
27	V	43	MARKETING	35,871	iCare Consulting Services LLC	100.00%		(35,871)	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			$ 274,486			$ 221,027	$ * (53,459)	39

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	21.39%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO	1
2	Yeruchom Levovitz	19.91%	PEARL PAVILION	FREEPORT	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO	2
3	Jeffrey Webster	5.29%	PARK VIEW REHAB CENTER	CHICAGO	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING CO	3
4	Eli Webster	2.46%	FOREST CITY REHAB & NURSING CENTER	ROCKFORD				4
5	EZ&A LLC	2.46%	PINE CREST HEALTH CENTER	HAZEL CREST				5
6	Howard Wengrow	7.27%	ROCK RIVER HEALTH CARE	ROCKFORD				6
7	Jay Wengrow	1.48%	BROOK CHATEAU	KANSAS CITY, MO				7
8	Dina Braunstein	1.48%	LEISURE TERRACE	OVERLAND PARK, KS				8
9	Moshe Levovitz	0.99%	BREEZY MEADOWS	BUTLER, MO				9
10	Kevin Chankin	2.46%						10
11	Chaim Levovitz	0.99%						11
12	Yehuda Orlansky	0.49%						12
13	Atied Associates, LLC	33.33%						13
14	Yaakov Ribowsky	0.49%						14
15	Rivky Kaminsky	0.49%						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	21.39%	See Attachment	6.01	15.03%	Alloc Salary	$ 18,177	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	19.91%	See Attachment	6.01	15.03%	Alloc Salary	17,906	17-7	2
3	Kevin Chankin	Owner	Clerical	2.46%	See Attachment	6.01	15.03%	Alloc Salary	30,046	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 66,129		13

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HEALTHCARE & FINANCIAL SER
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	441,943	10	$ 17,705	$	66,393	$ 2,660	1
2	3	HOUSEKEEPING	PATIENT DAYS	441,943	10	15,135		66,393	2,274	2
3	5	UTILITIES	PATIENT DAYS	441,943	10	10,527		66,393	1,582	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	47,591		66,393	7,150	4
5	17	S WEBSTER SALARY	PATIENT DAYS	441,943	10	120,995	120,995	66,393	18,177	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	441,943	10	119,190	119,190	66,393	17,906	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	12,272		66,393	1,844	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	18,896		66,393	2,839	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	69,058		66,393	10,375	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	1,177,077	1,177,077	66,393	176,833	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	5,755		66,393	865	11
12	26	INSURANCE	PATIENT DAYS	441,943	10	9,405		66,393	1,413	12
13	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	259,519		66,393	38,987	13
14	30	DEPRECIATION	PATIENT DAYS	441,943	10	20,479		66,393	3,077	14
15	34	RENT	PATIENT DAYS	441,943	10	147,325		66,393	22,133	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,050,929	$ 1,417,262		$ 308,114	25

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HC REAL ESTATE, LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	3,241		66,393	487	1
2	20	LICENSES & PERMITS	PATIENT DAYS	441,943	10	250		66,393	38	2
3	30	DEPRECIATION	PATIENT DAYS	441,943	10	27,389		66,393	4,115	3
4	32	INTEREST EXPENSE	PATIENT DAYS	441,943	10	18,587		66,393	2,792	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	441,943	10	40,000		66,393	6,009	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					$ 89,467	$		$ 13,441	25

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: iCare Consulting Services LLC
Street Address: 8131 Monticello
City / State / Zip Code: Skokie, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	441,943	10	$ 1,804	$	66,393	$ 271	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	472		66,393	71	2
3	10	NURSING SALARIES	PATIENT DAYS	441,943	10	1,055,519	1,084,019	66,393	158,570	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	441,943	10	110,378		66,393	16,582	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	57,864		66,393	8,693	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	369		66,393	55	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	45,733		66,393	6,870	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	131,573	131,573	66,393	19,766	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	7,055		66,393	1,060	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	14,224		66,393	2,137	10
11	25	AUTO & TRAVEL	PATIENT DAYS	345,177	7	36,142		66,393	6,952	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,461,133	$ 1,215,592		$ 221,027	25

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	MB Financial		X								2,143	6
7	Alloc Premier HC Realty	X									2,792	7
8					-							8
9	TOTAL Facility Related						$	$			$ 4,935	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,964)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (1,964)	14
15	TOTALS (line 9+line14)						$	$			$ 2,971	15

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River View Rehab Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052795

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-15-304-015	Long Term Care Facility	$ 120,770.98	$ 120,770.98
2.	10-23-324-047-0000	Home Office Allocation	$ 38,132.87	$ 5,728.69
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 158,903.85	$ 126,499.67

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 3,311	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.)		$ 126,780	2
3. Under or (over) accrual (line 2 minus line 1).		$ 123,469	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)		$ 180	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.		$ 123,649	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	92,229	10
2014	110,794	11
2015	120,771	12

Allocated from Premier HC Realty = $6009

Beginning accrual adjusted because the facility does not accrue for real estate taxes as they do not own the building.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River View Rehab Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052795

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,780 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Premier HC Realty			$ 2,854	1
2					2
3	TOTALS			$ 2,854	3

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		169,703	7,050		7,133	83	35,621	68
69	Financial Statement Depreciation			15,492			(15,492)		69
70	TOTAL (lines 4 thru 69)		$ 169,703	$ 22,542		$ 7,133	$ (15,409)	$ 35,621	70

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 169,703	$ 22,542		$ 7,133	$ (15,409)	$ 35,621	1
2	New Pipes For Water Heater-Hall Between Kitchen/Linen Room	2014	2,800		20	140	140	315	2
3	3 Hvac Rooftop Units (Out Of 12)	2015	30,000		20	1,500	1,500	3,000	3
4	Generator	2016	27,240		20	454	454	454	4
5	Water Heater	2016	6,545		20	273	273	273	5
6	1 Hvac Rooftop Unit (Out Of 12)	2016	7,830		20	196	196	196	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	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)		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	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)		$ 244,118	$ 22,542		$ 9,695	$ (12,847)	$ 39,858	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Premier Realty	2011	55,947	1,435	39	1,598	163	8,124	3
4	Allocated From Premier Realty	2012	7,123	183	39	204	21	1,018	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Premier Realty	2011	99,505	2,371	20	4,975	2,604	25,291	9
10	Allocated From Premier Realty	2012	2,884	74	20	144	70	721	10
11									11
12	Allocated From Premier Healthcare & Financial Services	2012	1,269	12	20	63	51	318	12
13	Allocated From Premier Healthcare & Financial Services	2016	2,975	2,975	20	149	(2,826)	149	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)		$ 169,703	$ 7,050		$ 7,133	$ 83	$ 35,621	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 169,703	$ 7,050		$ 7,133	$ 83	$ 35,621	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 169,703	$ 7,050		$ 7,133	$ 83	$ 35,621	34

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 52,201	$ 52	$ 6,059	$ 6,007	10	$ 25,886	71
72	Current Year Purchases	90	90	9	(81)	10	9	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 52,291	$ 142	$ 6,068	$ 5,926		$ 25,895	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 299,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,684	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,763	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,921)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 65,753	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Maplewood-Jane LLC

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:		203		$ 1,088,270			3
4	Additions							4
5								5
6	Allocated from Premier				10,114			6
7	TOTAL		203		$ 1,098,384 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 495 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$ -	$	21

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 351,122	$		$ 351,122	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			44,824			44,824	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			351,123			351,123	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				117,731		117,731	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					15,329	89,694		105,023	13
14	TOTAL			$		$ 762,398	$ 207,425		$ 969,823	14

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

Facility Name & ID Number River View Rehab Center **#** 0052795 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,457	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,645,898		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,547		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	6,803		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,855,705	$	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	14,375		15
16	Equipment, at Historical Cost	35,623		16
17	Accumulated Depreciation (book methods)	(21,696)		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): See Attached Schedule	1,015,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,043,302	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,899,007	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 516,369	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,764		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	468,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,175		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	62,299		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,066,552	$	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)**	$ 1,066,552	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,832,455	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,899,007	$	48

***(See instructions.)**

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,360,568	1
2	Restatements (describe):		2
3		(97,614)	3
4	Late Journal Entry		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,262,954	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,498,001	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	(1,928,500)	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)**	$ (430,499)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,832,455	24 *

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,782,396	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,782,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,032	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,964	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,964	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	191,706	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 191,706	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,980,098	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,334,923	31
32	Health Care	3,255,559	32
33	General Administration	2,156,669	33
	B. Capital Expense		
34	Ownership	1,223,860	34
	C. Ancillary Expense		
35	Special Cost Centers	1,010,049	35
36	Provider Participation Fee	501,037	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,482,097	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,498,001	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,498,001	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,258,310	44
45	Private Pay - Net Inpatient Revenue	352,051	45
46	Medicare - Net Inpatient Revenue	1,829,145	46
47	Other-(specify) Hospice	216,834	47
48	Other-(specify) Veteran	126,056	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,782,396	49

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

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

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

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,082	$ 114,404	$ 54.95	1
2	Assistant Director of Nursing	1,928	2,081	84,970	40.83	2
3	Registered Nurses	29,975	32,665	1,013,979	31.04	3
4	Licensed Practical Nurses	10,260	11,155	282,509	25.33	4
5	CNAs & Orderlies	73,306	84,319	964,451	11.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,170	5,754	80,156	13.93	8
9	Activity Director	1,832	2,000	31,580	15.79	9
10	Activity Assistants	7,630	8,101	72,439	8.94	10
11	Social Service Workers	16,846	18,286	254,050	13.89	11
12	Dietician					12
13	Food Service Supervisor	3,854	4,176	66,904	16.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,730	21,907	228,556	10.43	15
16	Dishwashers					16
17	Maintenance Workers	2,512	2,749	33,453	12.17	17
18	Housekeepers	20,958	22,818	228,955	10.03	18
19	Laundry	7,052	7,560	75,808	10.03	19
20	Administrator	1,976	2,081	113,930	54.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,922	7,722	157,957	20.46	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	3,065	3,307	46,427	14.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,992	238,763	$ 3,850,528 *	$ 16.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	387	$ 18,171	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	182,037	10-03	38
39	Pharmacist Consultant	322	12,890	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	49	2,512	11-03	44
45	Social Service Consultant	32	2,008	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	790	$ 236,418		49

C. CONTRACT NURSES

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arshad Rahman	Administrator	0	$ 113,930
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,930

B. Administrative - Other

Description	Amount
Management Fees- Premier HC & Financial Services	$ 655,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 655,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Marcum, LLP	Accounting Services	15,000
Yeruchom Levovitz	Computer Services	37
Point Click Care	Computer Services	19,804
Reliable Health Systems	Computer Services	16,290
Creative Technology	Computer Services	14,738
Zirmed	Computer Services	333
See Attachment	Legal Services	6,649
RN International	RN Licensing Consulting	22,500
MTS Consulting	Tax Consulting	3,784
MNS	Managed Care Consulting	750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 99,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,991
Unemployment Compensation Insurance	33,950
FICA Taxes	273,124
Employee Health Insurance	67,491
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	15,316
Christmas Expense	5,141
TOTAL (agree to Schedule V, line 22, col.8)	$ 494,013

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	13,609
Health Care Worker Background Check	
(Indicate # of checks performed 684)	6,847
Patient Background Checks	
ICLTC Dues	13,180
Licenses and Dues	4,913
Allocated from Premier HC & Financial	2,839
Allocated from Premier HC Realty	38
See Supplemental Schedule	55
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,471

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,464
Allocated from Premier HC & Financial	865
Allocated from iCare	1,060
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,389

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $19,671**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,706** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **501,037**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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