FOR BHF USE

LL1

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: 0052175

Facility Name: Rivershores Healthcare And Rehabilitation Centre, Llc

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

County: Lasalle

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,698	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	20,266	2,365	3,589	26,220	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,266	2,365	3,589	26,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.55%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 2,346

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation C # 0052175 Report Period Beginning: 01/01/16 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	217,439	32,115	7,371	256,925		256,925	34	256,959			1
2	Food Purchase		153,976		153,976		153,976	(4,588)	149,388			2
3	Housekeeping		3,557	138,641	142,198		142,198	447	142,645			3
4	Laundry		5,308	91,866	97,174		97,174		97,174			4
5	Heat and Other Utilities			127,780	127,780		127,780	948	128,728			5
6	Maintenance	43,790	14,494	83,441	141,725		141,725	(2,975)	138,750			6
7	Other (specify):*											7
8	TOTAL General Services	261,229	209,450	449,099	919,778		919,778	(6,135)	913,643			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,858,222	97,478	87,840	2,043,540		2,043,540	10,004	2,053,544			10
10a	Therapy	70,318			70,318		70,318		70,318			10a
11	Activities	125,931	7,934	907	134,772		134,772		134,772			11
12	Social Services	62,198			62,198		62,198	2,966	65,164			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,781	6,781			15
16	TOTAL Health Care and Programs	2,116,669	105,412	101,747	2,323,828		2,323,828	19,751	2,343,579			16
	C. General Administration											
17	Administrative	83,378		107,781	191,159		191,159	(76,583)	114,576			17
18	Directors Fees											18
19	Professional Services			235,565	235,565		235,565	(153,402)	82,163			19
20	Dues, Fees, Subscriptions & Promotions			37,046	37,046		37,046	(17,104)	19,942			20
21	Clerical & General Office Expenses	105,790	24,376	360,034	490,200		490,200	(199,825)	290,375			21
22	Employee Benefits & Payroll Taxes			486,058	486,058		486,058		486,058			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,011	4,011		4,011	503	4,514			24
25	Other Admin. Staff Transportation			9,845	9,845		9,845	2,262	12,107			25
26	Insurance-Prop.Liab.Malpractice			76,999	76,999		76,999	488	77,487			26
27	Other (specify):*							23,342	23,342			27
28	TOTAL General Administration	189,168	24,376	1,317,339	1,530,883		1,530,883	(420,320)	1,110,563			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,567,066	339,238	1,868,185	4,774,489		4,774,489	(406,704)	4,367,785			29

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc #0052175 Report Period Beginning: 01/01/16 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,644	34,644		34,644	102,685	137,329			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			999	999		999	1,606	2,605			32
33	Real Estate Taxes			50,598	50,598		50,598	2,523	53,121			33
34	Rent-Facility & Grounds			443,540	443,540		443,540	(442,368)	1,172			34
35	Rent-Equipment & Vehicles			14,398	14,398		14,398	277	14,675			35
36	Other (specify):*											36
37	**TOTAL Ownership**			544,179	544,179		544,179	(335,276)	208,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,162	515,408	693,570		693,570		693,570			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,491	212,491		212,491		212,491			42
43	Other (specify):*	24,530		19,769	44,299		44,299	(44,299)	(0)			43
44	**TOTAL Special Cost Centers**	24,530	178,162	747,668	950,360		950,360	(44,299)	906,061			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,591,596	517,400	3,160,032	6,269,028		6,269,028	(786,279)	5,482,749			45

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,675)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	101,395	30		9
10	Interest and Other Investment Income	(750)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	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	(11,194)	21		18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(237,735)	21		24
25	Fund Raising, Advertising and Promotional	(13,741)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(39)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(659,446)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (824,624)		$	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)	38,345		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 38,345		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (786,279)		37

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

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

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

Rivershores Healthcare And Rehabilitation Centre, Llc

ID# 0052175

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (67)	21	1
2	Medical Records	(1,679)	10	2
3	Veterans Expense	(1,283)	10	3
4	Marketing	(18,540)	43	4
5	Bank Charges	(5,219)	21	5
6	Marketing Salaries	(24,530)	43	6
7	Theft and Loss	(84)	21	7
8	Sequestration	(16,877)	21	8
9	Additional R&M	3,653	06	9
10	Capitalized R&M	(8,207)	06	10
11	Non-Allowable Legal	(28,495)	19	11
12	Rent for Sale Leaseback Arrangement	(443,540)	34	12
13	Marketing Travel	(1,229)	43	13
14	Vending Income	(1,774)	02	14
15	Out of Period Expense	(500)	21	15
16	PAC Dues	(3,294)	20	16
17	Non-Allowable Expense	(107,781)	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**	(659,446)		49

Rivershores Healthcare And Rehabilitation Centre, Llc

ID# 0052175

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 Rivershores Healthcare And Rehabilitation Centre, Llc **#** 0052175 **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			34									34	1
2	Food Purchase	(4,588)											(4,588)	2
3	Housekeeping			447									447	3
4	Laundry													4
5	Heat and Other Utilities			784	163								948	5
6	Maintenance	(4,554)		987	436	157							(2,975)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(9,142)		2,252	599	157							(6,135)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,963)		12,966									10,004	10
10a	Therapy													10a
11	Activities													11
12	Social Services			2,966									2,966	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,781									6,781	15
16	**TOTAL Health Care and Programs**	(2,963)		22,714									19,751	16
	C. General Administration													
17	Administrative	(107,781)		31,198									(76,583)	17
18	Directors Fees													18
19	Professional Services	(28,495)		(61,498)	62	(63,472)							(153,402)	19
20	Fees, Subscriptions & Promotions	(17,335)		215	16								(17,104)	20
21	Clerical & General Office Expenses	(271,714)		36,077	11	35,800							(199,825)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			102		402							503	24
25	Other Admin. Staff Transportation			304		1,958							2,262	25
26	Insurance-Prop.Liab.Malpractice			247	105	136							488	26
27	Other (specify):*			17,330		6,012							23,342	27
28	**TOTAL General Administration**	(425,324)		23,974	195	(19,164)							(420,320)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(437,429)		48,939	794	(19,007)							(406,704)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	101,395			1,290								102,685	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(750)			2,356								1,606	32
33	Real Estate Taxes				2,523								2,523	33
34	Rent-Facility & Grounds	(443,540)		8,506	(8,506)	1,172							(442,368)	34
35	Rent-Equipment & Vehicles			277									277	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(342,895)		8,783	(2,336)	1,172							(335,276)	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):*	(44,299)											(44,299)	43
44	**TOTAL Special Cost Centers**	(44,299)											(44,299)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(824,624)		57,722	(1,542)	(17,835)							(786,279)	45

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	1	DIETARY	$	MOSAIC HEALTHCARE	100.00%	$ 34	$ 34	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	447	447	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	784	784	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	987	987	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	31,506	31,506	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	2,966	2,966	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	6,781	6,781	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	31,198	31,198	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	966	966	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	215	215	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	56,896	56,896	25
26	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	6,991	6,991	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	102	102	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	304	304	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	247	247	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	17,330	17,330	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	8,506	8,506	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	277	277	32
33	V								33
34	V	19	BOOKKEEPING	43,924	MOSAIC HEALTHCARE	100.00%		(43,924)	34
35	V	19	ADMINISTRATIVE	18,540	MOSAIC HEALTHCARE	100.00%		(18,540)	35
36	V	10	MDS CONSULTANT	18,540	MOSAIC HEALTHCARE	100.00%		(18,540)	36
37	V	21	OFFICE CONSULTANT	27,810	MOSAIC HEALTHCARE	100.00%		(27,810)	37
38	V								38
39	Total			$ 108,814			$ 166,536	$ * 57,722	39

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	5	UTILITIES		4600 TOUHY, LLC	100.00%	163	$ 163	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	436	436	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	62	62	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	16	16	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	11	11	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	105	105	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,290	1,290	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,356	2,356	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,523	2,523	23
24	V								24
25	V	34	RENT	8,506	4600 TOUHY, LLC	100.00%		(8,506)	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			$ 8,506			$ 6,964	$ * (1,542)	39

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	6	MAINTENANCE & REPAIR	$	PLATINUM BILLING SOLUTIONS	30.00%	$ 157	$ 157	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	828	828	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	5,540	5,540	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	30,260	30,260	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	402	402	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	1,958	1,958	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	136	136	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	6,012	6,012	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,172	1,172	23
24	V								24
25	V	19	AR MANAGEMENT SERVICES	64,300	PLATINUM BILLING SOLUTIONS	30.00%		(64,300)	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			$ 64,300			$ 46,465	$ * (17,835)	39

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	CENTRAL ILLINOIS OPERATIONS LLC	99.99%	MOSAIC OF BEACON	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	TETRAD MANAGEMENT LLC	0.01%	MOSAIC OF LAKE SHORE	CHICAGO	MOSAIC HEALTHCARE	LINCOLNWOOD	BOOKKEEPING	2
3			MOSAIC OF MAYFIELD	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	3
4			MOSAIC OF SPRINGFIELD	SPRINGFIELD, IL	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	AR MANAGEMENT SERV	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILTATION CENTRE	MORTON, IL				7
8			MOSAIC OF UPTOWN	CHICAGO				8
9			MORTON TERRACE HEALTHCARE & REHABILITATION CETNRE I	MORTON, IL				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation C # 0052175 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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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: MOSAIC HEALTHCARE
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	483,176	10	$ 625	$	26,220	$ 34	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		26,220	447	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		26,220	784	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		26,220	987	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	26,220	31,506	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	26,220	2,966	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		26,220	6,781	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	26,220	31,198	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		26,220	966	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		26,220	215	10
11	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	483,176	10	1,048,463	1,048,463	26,220	56,896	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		26,220	6,991	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		26,220	102	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		26,220	304	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		26,220	247	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		26,220	17,330	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		26,220	8,506	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		26,220	277	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,068,885	$ 2,258,616		$ 166,536	25

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	483,176	10	3,010		26,220	163	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		26,220	436	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		26,220	62	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		26,220	16	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		26,220	11	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		26,220	105	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		26,220	1,290	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		26,220	2,356	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		26,220	2,523	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					$ 128,334	$		$ 6,964	25

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	$ 2,885	$	26,220	$ 157	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		26,220	828	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		26,220	5,540	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	26,220	30,260	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		26,220	402	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		26,220	1,958	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		26,220	136	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		26,220	6,012	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		26,220	1,172	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					$ 856,240	$ 557,621		$ 46,465	25

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation C # 0052175 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	Allocated from 4600 Touhy	X									2,356	6
7												7
8					-							8
9	TOTAL Facility Related						$	$			$ 2,356	9
	B. Non-Facility Related*											
10	Interest Income		X								(750)	10
11	Interest Expense		X								999	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ 249	14
15	TOTALS (line 9+line14)						$	$			$ 2,605	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 Rivershores Healthcare And Rehabilitation C # 0052175 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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.**	$ 49,231	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.)		$ 52,129	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,898	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,223	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,121	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	46,678	9
2013	48,642	10
2014	48,271	11
2015	49,606	12

2016 Accrual: $49,606 x 1.01 = $50,223 (Rounded)
Allocated from 4600 Touhy LLC: $2,523

	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rivershores Healthcare And Rehabilitation Centre, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 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.	15-49-325-027	Long Term Care Property	$ 48,934.26	$ 48,934.26
2.	15-49-325-026	Long Term Care Property	$ 671.94	$ 671.94
3.	See Attached	Home Office Allocation	$ 89,919.35	$ 2,439.78
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,525.55	$ 52,045.98

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.

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 Rivershores Healthcare And Rehabilitation Centre, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0052175

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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 217,814	1
2	Allocated from 4600 Touhy LLC			4,884	2
3	TOTALS			$ 222,698	3

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	103		2013	1967	$ 1,765,573	$	39	$ 45,271	$ 45,271	$ 181,084	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		56,892	1,290		2,380	1,090	11,616	68
69	Financial Statement Depreciation			34,644			(34,644)		69
70	TOTAL (lines 4 thru 69)		$ 1,822,465	$ 35,934		$ 47,651	$ 11,717	$ 192,700	70

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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		$ 1,822,465	$ 35,934		$ 47,651	$ 11,717	$ 192,700	1
2	Water Boiler	2013	6,725		20	336	336	1,261	2
3	Water Heater	2013	9,400		20	470	470	1,606	3
4	Water Heater Repair	2013	3,011		20	151	151	577	4
5	Generator Repair	2013	2,611		20	131	131	511	5
6	Wiring For Telecom	2014	7,176		20	1,025	1,025	2,563	6
7	Piping	2014	3,391		20	170	170	495	7
8	Piping	2014	3,026		20	151	151	454	8
9	New Rooftop A/C Unit	2014	3,020		20	151	151	390	9
10	Flooring For Patio & Resident Room	2014	6,737		20	337	337	730	10
11	Signage	2014	6,858		20	343	343	914	11
12	Upgrade Code Alert System	2015	6,684		20	1,337	1,337	2,674	12
13	Fire Alarm - Replace Annunciator At North Nurses Station	2015	3,087		20	154	154	180	13
14	Replacement Hot Water Boiler	2016	5,875		20	294	294	294	14
15	Repaired Electrical Wiring On Facility Hubs	2016	5,227		20	261	261	261	15
16	Repaired Leak Under Concrete Floor	2016	2,980		20	149	149	149	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,898,272	$ 35,934		$ 53,110	$ 17,176	$ 205,759	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 4600 Touhy LLC	2012	27,863	714	30	929	215	4,644	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	468		20	23	23	94	9
10	Allocated from Mosaic Healthcare	2012	5,817		20	291	291	1,454	10
11									11
12	Allocated from 4600 Touhy LLC	2012	17,944	462	20	897	435	4,486	12
13	Allocated from 4600 Touhy LLC	2013	4,366	103	20	218	115	873	13
14	Allocated from 4600 Touhy LLC	2014	434	11	20	22	11	65	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)		$ 56,892	$ 1,290		$ 2,380	$ 1,090	$ 11,616	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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		$ 56,892	$ 1,290		$ 2,380	$ 1,090	$ 11,616	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)		$ 56,892	$ 1,290		$ 2,380	$ 1,090	$ 11,616	34

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre,]# 0052175 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	$ 769,172	$	$ 84,219	$ 84,219	10	$ 313,520	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	13,936				10	13,936	73
74								74
75	TOTALS	$ 783,108	$	$ 84,219	$ 84,219		$ 327,456	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic HC	2016	$ 5,155	$	$	$	5	$ 5,155	76
77										77
78										78
79										79
80	TOTALS			$ 5,155	$	$	$		$ 5,155	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,909,234	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,934	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,329	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 101,395	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 538,370	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		103		$ 443,540			3
4	Additions							4
5					(443,540)			5
6	Allocated from Platinum Billing Solutions				1,172			6
7	TOTAL		103		$ 1,172 **			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: $ 3,418 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Challenger Bus	$	$ 11,257	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 11,257	21

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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 Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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	$		$ 204,767	$		$ 204,767	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,757			60,757	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			217,168			217,168	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				166,411		166,411	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					32,716	11,751		44,467	13
14	TOTAL			$		$ 515,408	$ 178,162		$ 693,570	14

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

STATE OF ILLINOIS

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 **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	$ 30,354	$	1
2	Cash-Patient Deposits	11,557		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,885,737		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,075		6
7	Other Prepaid Expenses	2,214		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	31,909		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,009,846	$	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	47,389		15
16	Equipment, at Historical Cost	128,038		16
17	Accumulated Depreciation (book methods)	(87,904)		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	628,970		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 716,493	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,726,339	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,767,352	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,557		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,307		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,232		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,223		32
33	Accrued Interest Payable	2,782		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	157,793		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,013,246	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,622,989		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,622,989	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,636,235	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (909,896)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,726,339	$	48

***(See instructions.)**

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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**	$ (189,582)	1
2	Restatements (describe):		2
3	**PY Contributions**	32,916	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (156,666)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(753,230)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (753,230)	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)**	$ (909,896)	24 *

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, # 0052175 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	$ 6,176,778	1
2	Discounts and Allowances for all Levels	(1,561,430)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,615,348	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	756,123	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 756,123	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,675	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	124,673	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,474	19
20	Radiology and X-Ray	1,773	20
21	Other Medical Services	1,462	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 140,057	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	750	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 750	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,520	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,520	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,515,798	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	919,778	31
32	Health Care	2,323,828	32
33	General Administration	1,530,883	33
	B. Capital Expense		
34	Ownership	544,179	34
	C. Ancillary Expense		
35	Special Cost Centers	737,869	35
36	Provider Participation Fee	212,491	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,269,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	(753,230)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (753,230)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,271,234	44
45	Private Pay - Net Inpatient Revenue	524,637	45
46	Medicare - Net Inpatient Revenue	630,339	46
47	Other-(specify) Hospice, Managed Care Medicare	169,643	47
48	Other-(specify) Veterans, Insurance	19,495	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,615,348	49

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

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

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

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

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 Report Period Beginning: 01/01/16 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	1,897	2,062	$ 68,031	$ 32.99	1
2	Assistant Director of Nursing	1,785	1,940	60,250	31.06	2
3	Registered Nurses	20,102	21,850	615,085	28.15	3
4	Licensed Practical Nurses	12,127	13,182	305,418	23.17	4
5	CNAs & Orderlies	60,586	65,854	783,004	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,170	2,359	70,318	29.81	8
9	Activity Director	2,227	2,420	54,786	22.64	9
10	Activity Assistants	7,438	8,085	71,145	8.80	10
11	Social Service Workers	2,581	2,805	49,686	17.71	11
12	Dietician					12
13	Food Service Supervisor	2,117	2,301	33,604	14.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,625	18,071	183,835	10.17	15
16	Dishwashers					16
17	Maintenance Workers	1,940	2,109	43,790	20.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,928	1,993	83,378	41.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,928	2,080	37,198	17.88	23
24	Clerical	4,276	4,647	68,592	14.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,910	2,077	26,434	12.73	31
32	Other Health Care(specify)					32
33	Other(specify)	2,612	2,840	37,042	13.04	33
34	TOTAL (lines 1 - 33)	144,249	156,675	$ 2,591,596 *	$ 16.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,371	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant	Monthly	530	10-03	37
38	Nurse Consultant	Monthly	19,600	10-03	38
39	Pharmacist Consultant	Monthly	7,619	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	907	11-03	44
45	Social Service Consultant				45
46	Other(specify) MDS Consultant	Monthly	18,540	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 67,567		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	133	5,301	10-03	51
52	Certified Nurse Assistants/Aides	1,450	36,250	10-03	52
53	TOTAL (lines 50 - 52)	1,583	$ 41,551		53

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, L # 0052175 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anna Johnson	Administrator	0.00%	$ 12,425
Tiffany Green	Administrator	0.00%	70,953
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,378

B. Administrative - Other

Description	Amount
Management Fees - Tetrad Management	$ 107,781
TOTAL (agree to Schedule V, line 17, col. 3)	$ 107,781
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 19,336
Ability Network	Data Processing	8,234
Creative Technology	Data Processing	3,731
E-One Solutions	Data Processing	79
Galaxy Software	Data Processing	1,315
Health MedX LLC	Data Processing	22,693
Mosaic HC	Data Processing	1,123
Prospect Resources	Energy Procurement	1,512
Madison Specs	Cost Segregation	2,575
Management Network Services	Management Consultant	1,500
See Attached	Legal	32,921
See Supplemental Schedule		140,545
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 235,564

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,535
Unemployment Compensation Insurance	39,357
FICA Taxes	192,720
Employee Health Insurance	54,891
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	16,604
Holiday Expense	2,483
Other Employee Benefits	3,468
TOTAL (agree to Schedule V, line 22, col.8)	$ 486,058

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	$
Advertising: Employee Recruitment	4,168
Health Care Worker Background Check	2,259
(Indicate # of checks performed 226)	
Patient Background Checks	
Dues and Subscriptions	8,957
License and Permits	4,327
Allocated from Mosaic HC	215
Allocated from 4600 Touhy LLC	16
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,942

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,011
Allocated from Mosaic HC	102
Allocated from Platinum Billing Solutions	402
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,515

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rivershores Healthcare And Rehabilitation Centre, Llc # 0052175 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. **IL Council on Long Term Care: $9,981**

(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. $ **13,966** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **12/312014**

(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. $ **212,491**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,675**

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

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

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

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