FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0052795

Facility Name: River View Rehab Center LLC

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

County: Kane

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach **Telephone Number:** (773) 945-9528
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 01/01/2018 to 12/31/2018 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) Joshua S. Banach, CPA
(Title) Asst. Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	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	58,726	1,185	5,240	65,151	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,726	1,185	5,240	65,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.93%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 3,725

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	327,812	45,526	23,461	396,799		396,799		396,799			1
2	Food Purchase		347,972		347,972		347,972	1,691	349,663			2
3	Housekeeping	234,039	34,344		268,383		268,383	4,357	272,740			3
4	Laundry	76,681	22,836		99,517		99,517		99,517			4
5	Heat and Other Utilities			195,820	195,820		195,820	(17,716)	178,104			5
6	Maintenance	128,890		106,007	234,897		234,897	(12,179)	222,718			6
7	Other (specify):*											7
8	TOTAL General Services	767,422	450,678	325,288	1,543,388		1,543,388	(23,847)	1,519,541			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,826,501	32,839	192,350	3,051,690		3,051,690	(127,453)	2,924,237			10
10a	Therapy	83,781	7,879		91,660		91,660		91,660			10a
11	Activities	116,663	9,018	2,572	128,253		128,253		128,253			11
12	Social Services	276,965	1,833	1,338	280,136		280,136		280,136			12
13	CNA Training											13
14	Program Transportation			40,428	40,428		40,428		40,428			14
15	Other (specify):*							5,866	5,866			15
16	TOTAL Health Care and Programs	3,303,910	51,569	251,088	3,606,567		3,606,567	(121,587)	3,484,980			16
	C. General Administration											
17	Administrative	195,644		667,000	862,644		862,644	(548,611)	314,033			17
18	Directors Fees											18
19	Professional Services			104,134	104,134		104,134	3,332	107,466			19
20	Dues, Fees, Subscriptions & Promotions			78,583	78,583		78,583	(20,106)	58,477			20
21	Clerical & General Office Expenses	78,360		214,646	293,006		293,006	50,702	343,708			21
22	Employee Benefits & Payroll Taxes			561,091	561,091		561,091	(6,319)	554,772			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,274	1,274		1,274	1,643	2,917			24
25	Other Admin. Staff Transportation			5,282	5,282		5,282	6,597	11,879			25
26	Insurance-Prop.Liab.Malpractice			316,547	316,547		316,547	2,742	319,289			26
27	Other (specify):*							53,249	53,249			27
28	TOTAL General Administration	274,004		1,948,557	2,222,561		2,222,561	(456,771)	1,765,790			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,345,336	502,247	2,524,933	7,372,516		7,372,516	(602,205)	6,770,311			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.

River View Rehab Cener
Travel Detail
12/31/2018

Account Number	Date	Employee	Function	Description	Amount
8600.6	12/31/2018	Kathi Tolle	Admissions	Mileage around Elgin area	4,196.67
8600.6	12/31/2018	Petty Cash	A&G	Mileage within Elgin area- For Facility Errands	1,085.51
	12/31/2018	Allocated From iCare Consulting			6,597.00
		Total			11,879.18

Facility Name & ID Number River View Rehab Center LLC #0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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							619,794	619,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,059	7,059		7,059	936,567	943,626			32
33	Real Estate Taxes			119,858	119,858		119,858	6,096	125,954			33
34	Rent-Facility & Grounds			1,517,000	1,517,000		1,517,000	(1,493,376)	23,624			34
35	Rent-Equipment & Vehicles			2,596	2,596		2,596		2,596			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,646,513	1,646,513		1,646,513	69,081	1,715,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195,699	906,315	1,102,014		1,102,014		1,102,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			478,390	478,390		478,390		478,390			42
43	Other (specify):*			30,509	30,509		30,509	(30,509)				43
44	**TOTAL Special Cost Centers**		195,699	1,415,214	1,610,913		1,610,913	(30,509)	1,580,404			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,345,336	697,946	5,586,660	10,629,942		10,629,942	(563,633)	10,066,309			45

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				4
5	Telephone, TV & Radio in Resident Rooms	(20,483)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	619,794	30		9
10	Interest and Other Investment Income	(9,788)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(1,554)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(99,870)	21		24
25	Fund Raising, Advertising and Promotional	(3,677)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,736)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(86,282)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 385,841		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 385,841		37

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

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

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

River View Rehab Center LLC

ID# 0052795

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (36,237)	21	1
2	Vending Income	(1,250)	02	2
3	Marketing	(2,609)	43	3
4	Bank Charges	(9,032)	21	4
5	Miscellaneous Income	(696)	21	5
6	PAC Dues	(16,433)	20	6
7	Building Co- Professional Fees	(7,779)	19	7
8	Non-Allowable Legal	(2,903)	19	8
9	Medical Record Income	(120)	10	9
10	PPA- Employee Expense	(6,319)	22	10
11	Capitalized R&M	(2,904)	06	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(86,282)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,313)	0	2,210	0	794	0	0	0	0	0	0	1,691	2
3	Housekeeping	0	0	4,357	0	0	0	0	0	0	0	0	4,357	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(20,483)	0	2,767	0	0	0	0	0	0	0	0	(17,716)	5
6	Maintenance	(2,904)	0	4,087	0	(13,362)	0	0	0	0	0	0	(12,179)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(24,700)	0	13,421	0	(12,568)	0	0	0	0	0	0	(23,847)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(120)	0	0	0	(127,333)	0	0	0	0	0	0	(127,453)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	5,866	0	0	0	0	0	0	5,866	15
16	**TOTAL Health Care and Programs**	(120)	0	0	0	(121,467)	0	0	0	0	0	0	(121,587)	16
	C. General Administration													
17	Administrative	0	0	(575,554)	0	26,943	0	0	0	0	0	0	(548,611)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,682)	7,778	1,702	152	4,382	0	0	0	0	0	0	3,332	19
20	Fees, Subscriptions & Promotions	(20,610)	0	435	11	58	0	0	0	0	0	0	(20,106)	20
21	Clerical & General Office Expenses	(159,125)	0	154,305	0	55,522	0	0	0	0	0	0	50,702	21
22	Employee Benefits & Payroll Taxes	(6,319)	0	0	0	0	0	0	0	0	0	0	(6,319)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	966	0	677	0	0	0	0	0	0	1,643	24
25	Other Admin. Staff Transportation	0	0	0	0	6,597	0	0	0	0	0	0	6,597	25
26	Insurance-Prop.Liab.Malpractice	0	0	819	0	1,923	0	0	0	0	0	0	2,742	26
27	Other (specify):*	0	0	37,220	0	16,029	0	0	0	0	0	0	53,249	27
28	**TOTAL General Administration**	(196,736)	7,778	(380,107)	163	112,131	0	0	0	0	0	0	(456,771)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(221,556)	7,778	(366,686)	163	(21,904)	0	0	0	0	0	0	(602,205)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	619,794	0	0	0	0	0	0	0	0	0	0	619,794	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,788)	943,604	0	2,751	0	0	0	0	0	0	0	936,567	32
33	Real Estate Taxes	0	0	0	6,096	0	0	0	0	0	0	0	6,096	33
34	Rent-Facility & Grounds	0	(1,517,000)	34,597	(10,973)	0	0	0	0	0	0	0	(1,493,376)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	610,006	(573,396)	34,597	(2,126)	0	0	0	0	0	0	0	69,081	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,609)	0	0	0	(27,900)	0	0	0	0	0	0	(30,509)	43
44	**TOTAL Special Cost Centers**	(2,609)	0	0	0	(27,900)	0	0	0	0	0	0	(30,509)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	385,841	(565,618)	(332,089)	(1,963)	(49,804)	0	0	0	0	0	0	(563,633)	45

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,517,000	River View Rehab Cener Realty LLC	100.00%	$	$ (1,517,000)	1
2	V	32	Interest Expense		River View Rehab Cener Realty LLC	100.00%	943,604	943,604	2
3	V	19	Professional Fees		River View Rehab Cener Realty LLC	100.00%	7,778	7,778	3
4	V	33	Real Estate Taxes	115,892	River View Rehab Cener Realty LLC	100.00%	115,892		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			$ 1,632,892			$ 1,067,274	$ * (565,618)	14

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	21.39%	Center Home Hispanic Elderly	Chicago	Premier HC & Financ	Skokie	Consulting Co	1
2	Yeruchom Levovitz	19.91%	Pine Crest Health Center	Hazel Crest	Premier HC Realty	Skokie	Building Co	2
3	Jeffrey Webster	5.29%	Park View Rehab Center	Chicago	iCare Consulting Servi	Skokie	Consulting Co	3
4	Eli Webster	2.46%	Forest City Rehab & Nursing	Rockford	RV Rehab Realty	Elgin	Building Co	4
5	EZ&A LLC	2.46%	Rock River Health Care	Rockford				5
6	Howard Wengrow	7.27%	Pearl Pavilion	Freeport				6
7	Jay Wengrow	1.48%	Prairie Oasis	South Holland				7
8	Dina Braunstein	1.48%	Oak Park Oasis	Oak Park				8
9	Moshe Levovitz	0.99%	Austin Oasis	Chicago				9
10	Kevin Chankin	2.46%						10
11	Yehuda Orlansky	0.49%						11
12	Atied Associates LLC	33.33%						12
13	Yaakov Ribowsky	.50%						13
14	Rivky Kaminsky	.50%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	Premier Healthcare & Financial Services	100.00%	$ 2,210	$ 2,210	15
16	V	03	Housekeeping		Premier Healthcare & Financial Services	100.00%	4,357	4,357	16
17	V	05	Utilities		Premier Healthcare & Financial Services	100.00%	2,767	2,767	17
18	V	06	Repairs & Maintenance		Premier Healthcare & Financial Services	100.00%	4,087	4,087	18
19	V	17	Administrative Expenses		Premier Healthcare & Financial Services	100.00%	91,446	91,446	19
20	V	19	Professional Fees		Premier Healthcare & Financial Services	100.00%	1,702	1,702	20
21	V	20	Dues & Subscriptions		Premier Healthcare & Financial Services	100.00%	435	435	21
22	V	21	Clerical & General Salaries		Premier Healthcare & Financial Services	100.00%	146,029	146,029	22
23	V	21	Clerical & General Other Costs		Premier Healthcare & Financial Services	100.00%	8,276	8,276	23
24	V	24	Seminar & Education		Premier Healthcare & Financial Services	100.00%	966	966	24
25	V	26	Insurance		Premier Healthcare & Financial Services	100.00%	819	819	25
26	V	27	Employee Benefits		Premier Healthcare & Financial Services	100.00%	37,220	37,220	26
27	V	34	Rent Expense		Premier Healthcare & Financial Services	100.00%	34,597	34,597	27
28	V	17	Consulting Fees	667,000	Premier Healthcare & Financial Services	100.00%		(667,000)	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			$ 667,000			$ 334,911	$ * (332,089)	39

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Premier HC Real Estate, LLC	100.00%	$ 152	$ 152	15
16	V	20	Dues & Subscriptions		Premier HC Real Estate, LLC	100.00%	11	11	16
17	V	32	Interest Expense		Premier HC Real Estate, LLC	100.00%	2,751	2,751	17
18	V	33	Real Estate Tax		Premier HC Real Estate, LLC	100.00%	6,096	6,096	18
19	V	34	Rental Income	10,973	Premier HC Real Estate, LLC	100.00%		(10,973)	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			$ 10,973			$ 9,010	$ * (1,963)	39

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	iCare Consulting Services LLC	100.00%	$ 794	$ 794	15
16	V	06	Maint & Plant Operation Salary	29,300	iCare Consulting Services LLC	100.00%	15,938	(13,362)	16
17	V	10	Nursing Salary	174,000	iCare Consulting Services LLC	100.00%	46,667	(127,333)	17
18	V	15	Nursing Benefits/Taxes		iCare Consulting Services LLC	100.00%	5,866	5,866	18
19	V	17	Admin Salary- Non Related		iCare Consulting Services LLC	100.00%	26,943	26,943	19
20	V	19	Professional Fees		iCare Consulting Services LLC	100.00%	4,382	4,382	20
21	V	20	Dues & Subscriptions		iCare Consulting Services LLC	100.00%	58	58	21
22	V	21	A&G Expenses	32,300	iCare Consulting Services LLC	100.00%	3,175	(29,125)	22
23	V	21	A&G Salaries		iCare Consulting Services LLC	100.00%	84,647	84,647	23
24	V	24	Seminars & Education		iCare Consulting Services LLC	100.00%	677	677	24
25	V	25	Auto & Travel		iCare Consulting Services LLC	100.00%	6,597	6,597	25
26	V	26	Insurance		iCare Consulting Services LLC	100.00%	1,923	1,923	26
27	V	27	Employee Benefits/PR Taxes		iCare Consulting Services LLC	100.00%	16,029	16,029	27
28	V	43	Marketing Consultant	27,900	iCare Consulting Services LLC	100.00%		(27,900)	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			$ 263,500			$ 213,696	$ * (49,804)	39

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Member	Administrative	21.39%	See Attached	6.10	15.24%	Alloc Salary	$ 30,482	17-7	1
2	Yeruchom Levovitz	Member	Administrative	19.91%	See Attached	6.10	15.24%	Alloc Salary	30,482	17-7	2
3	Kevin Chankin	Member	Administrative	2.46%	See Attached	6.10	15.24%	Alloc Salary	30,482	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12	As necessary, the amounts reported above have been adjusted to reflect only HFS allowable costs										12
13								TOTAL	$ 91,446		13

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

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	02	Food	Resident Days	427,478	10	$ 14,500	$	65,151	$ 2,210	1
2	03	Housekeeping	Resident Days	427,478	10	28,586		65,151	4,357	2
3	05	Utilities	Resident Days	427,478	10	18,155		65,151	2,767	3
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817		65,151	4,087	4
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	65,151	91,445	5
6	19	Professional Fees	Resident Days	427,478	10	11,167		65,151	1,702	6
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851		65,151	435	7
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	65,151	146,029	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299		65,151	8,276	9
10	24	Seminar & Education	Resident Days	427,478	10	6,339		65,151	966	10
11	26	Insurance	Resident Days	427,478	10	5,376		65,151	819	11
12	27	Employee Benefits	Resident Days	427,478	10	244,216		65,151	37,220	12
13	34	Rent Expense	Resident Days	427,478	10	227,000		65,151	34,597	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					$ 2,197,453	$ 1,558,147		$ 334,910	25

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Resident Days	427,478	10	$ 1,000	$	65,151	$ 152	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75		65,151	11	2
3	32	Interest Expense	Resident Days	427,478	10	18,053		65,151	2,751	3
4	33	Real Estate Tax	Resident Days	427,478	10	40,000		65,151	6,096	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					$ 59,128	$		$ 9,010	25

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	02	Food	Resident Days	313,091	7	$ 3,818	$	65,151	$ 794	1
2	06	Maint & Plant Operation Salary	Resident Days	313,091	7	76,592	76,576	65,151	15,938	2
3	10	Nursing Salary	Resident Days	313,091	7	224,262	224,262	65,151	46,667	3
4	15	Nursing Benefits/Taxes	Resident Days	313,091	7	28,189		65,151	5,866	4
5	17	Admin Salary- Non Related	Resident Days	313,091	7	129,477	129,477	65,151	26,943	5
6	19	Professional Fees	Resident Days	313,091	7	21,060		65,151	4,382	6
7	20	Dues & Subscriptions	Resident Days	313,091	7	280		65,151	58	7
8	21	A&G Expenses	Resident Days	313,091	7	15,257		65,151	3,175	8
9	21	A&G Salaries	Resident Days	313,091	7	406,781	406,781	65,151	84,647	9
10	24	Seminars & Education	Resident Days	313,091	7	3,253		65,151	677	10
11	25	Auto & Travel	Resident Days	313,091	7	31,703		65,151	6,597	11
12	26	Insurance	Resident Days	313,091	7	9,242		65,151	1,923	12
13	27	Employee Benefits/PR Taxes	Resident Days	313,091	7	77,031		65,151	16,029	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,026,943	$ 837,096		$ 213,696	25

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	MB Financial		X	Mortgage			$	$ 15,090,950			$ 943,604	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				30,000			7,059	6
7	Allocated From Premier RE		X								2,751	7
8												8
9	TOTAL Facility Related						$	$ 15,120,950			$ 953,414	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,788)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,788)	14
15	TOTALS (line 9+line14)						$	$ 15,120,950			$ 943,626	15

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

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

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	20,197	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.)	$	125,954	2
3. Under or (over) accrual (line 2 minus line 1).	$	105,757	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	20,197	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.	$	125,954	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	92,229	8
	2014	110,794	9
	2015	120,771	10
	2016	121,181	11
	2017	115,892	12

Allocated From Premier RE: $6,096

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River View Rehab Center LLC COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052795

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (773) 945 9528 FAX #: (773) 945-9521

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-15-304-015	Long Term Care Facility	$ 115,892.00	$ 115,892.00
2.	10-23-324-047-0000	Home Office Allocation	$ 36,245.26	$ 5,524.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 152,137.26	$ 121,416.06

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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		2017	$ 848,722	1
2	Allocated From Premier RE			2,896	2
3	TOTALS			$ 851,618	3

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	203		2017	1972	$ 13,126,827	$	35	$ 375,052	$ 375,052	$ 750,104	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	2,800		20	140	140	595	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,129,627	$		$ 375,192	$ 375,192	$ 750,699	70

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,129,627	$		$ 375,192	$ 375,192	$ 750,699	1
2	3 HVAC Rooftop Units (Out of 12)	2015	30,000		20	1,500	1,500	6,000	2
3	Generator	2016	27,240		20	1,362	1,362	2,838	3
4	Water Heater	2016	6,545		20	327	327	927	4
5	1 HVAC Rooftop Unit (Out of 12)	2016	7,830		20	392	392	979	5
6	Intstallation of New Call Lights in Hallway 2200, 2300, Lobby	2017	9,682		20	484	484	2,098	6
7	Install Breakers For Generator	2017	6,500		20	325	325	1,408	7
8	Generator- Drawings	2017	3,500		20	175	175	700	8
9	New Car Sill For Front Elevator	2017	4,200		20	210	210	420	9
10	Repair of circulation and copper piping for common handsink	2018	2,904		20	145	145	145	10
11	Electrical:HVAC & light fixtures-1st floor/generator/driveway	2018	6,500		20	325	325	325	11
12	Laundry Room-5 Ton RTU Unit w/ gas & electric connections	2018	7,650		20	383	383	383	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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	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
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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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	1
2	Building Company								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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 13,242,178	$		$ 380,820	$ 380,820	$ 766,922	1
2	Related Party Building Allocations								2
3	Allocated From Premier Realty	2011	56,758		20	1,622	1,622	12,973	3
4	Allocated From Premier Realty	2012	7,226		20	206	206	1,445	4
5									5
6									6
7									7
8	Related Party Leasehold Improvement Allocations								8
9	Allocated From Premier Realty	2011	100,947		20	5,047	5,047	40,379	9
10	Allocated From Premier Realty	2012	2,926		20	146	146	1,024	10
11									11
12									12
13	Allocated From Premier HC & Financial Services	2012	1,288		20	64	64	451	13
14	Allocated From Premier HC & Financial Services	2016	3,018		20	151	151	453	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)		$ 13,414,341	$		$ 388,056	$ 388,056	$ 823,647	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 13,414,341	$		$ 388,056	$ 388,056	$ 823,647	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
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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)		$ 13,414,341	$		$ 388,056	$ 388,056	$ 823,647	34

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 2,317,379	$	$ 231,738	$ 231,738		$ 490,513	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,317,379	$	$ 231,738	$ 231,738		$ 490,513	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,583,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 619,794	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 619,794	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,314,160	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.

River View Rehab Center
12/31/2018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
River View Rehab Center	8,383		838	838	6,696
Premier Healthcare & Financial	11,209		1,121	1,121	7,353
Premier Real Estate	33,336		3,334	3,334	23,574
River View Rehab Center Realty	2,264,451		226,445	226,445	452,890
Total	2,317,379	-	231,738	231,738	490,513

Current Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
River View Rehab Center					
Premier Healthcare & Financial					
Premier Real Estate					
River View Rehab Center Realty					
Total	-	-	-	-	-

Fully Depreciated Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
River View Rehab Center					
Premier Healthcare & Financial					
Premier Real Estate					
River View Rehab Center Realty					
Total	-	-	-	-	-

Total Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
River View Rehab Center	8,383	-	838	838	6,696
Premier Healthcare & Financial	11,209	-	1,121	1,121	7,353
Premier Real Estate	33,336	-	3,334	3,334	23,574
River View Rehab Center Realty	2,264,451	-	226,445	226,445	452,890
Total	2,317,379	-	231,738	231,738	490,513

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Premier HC				23,624			6
7	TOTAL				$ 23,624 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,596 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

FACILITY NAME	**River View Rehab Center**
FACILITY NUMBER	**0052795**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

DESCRIPTION	AMOUNT
COPIER	2,596
TOTAL	2,596

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.

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		hrs	$		$ 369,491	$		$ 369,491	1
2	Licensed Speech and Language Development Therapist		hrs			70,379			70,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			439,871			439,871	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				86,100		86,100	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					26,574	109,599		136,174	13
14	TOTAL			$		$ 906,315	$ 195,699		$ 1,102,015	14

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

FACILITY NAME	**River View Rehab Center LLC**
FACILITY NUMBER	**0052795**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING SPECIAL SERVICES

SUPPLIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 6)

DESCRIPTION	AMOUNT
OXYGEN SUPPLY	5,669
NRS SUPLY N-CHRGE	95,515
GLOVES	8,415
	-
	-
	-
	-
	-
	-
	-
	109,599

OTHER- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 5)

DESCRIPTION	AMOUNT
G TUBE	16,213
X-RAYS	6,362
LABORATORY	3,999
	-
	-
	-
	-
	-
	-
	-
	26,574

SALARIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 3)

DESCRIPTION	AMOUNT
	-
	-
	-
	-
	-
	-
	-
	-

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 101,011	$ 153,731	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,552,567	1,552,567	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,931	52,931	6
7	Other Prepaid Expenses	700	700	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	91,614	149,560	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,798,823	$ 1,909,489	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,448,154	13
14	Buildings, at Historical Cost		10,355,801	14
15	Leasehold Improvements, at Historical Cost	74,382	634,150	15
16	Equipment, at Historical Cost	39,448	2,996,751	16
17	Accumulated Depreciation (book methods)	(26,631)	(425,950)	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	1,053,084	1,180,897	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,140,283	$ 17,189,804	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,939,106	$ 19,099,293	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 536,220	$ 536,220	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,030	3,030	28
29	Short-Term Notes Payable	30,000	30,000	29
30	Accrued Salaries Payable	436,175	436,175	30
31	Accrued Taxes Payable (excluding real estate taxes)	42,531	42,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,197	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	49,160	49,160	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,097,117	$ 1,117,313	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,090,950	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,036,084	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 16,127,034	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,097,117	$ 17,244,347	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,841,990	$ 1,854,946	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,939,106	$ 19,099,293	48

***(See instructions.)**

FACILITY NAME	**River View Rehab Center LLC**
FACILITY NUMBER	**0052795**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM COST REPORT	42,952	42,952
DUE FROM OTHERS	1,924	1,924
DUE FROM PRIOR OWNER	46,738	46,738
REAL ESTATE ESCROW		57,946
	91,614	149,560

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
ACCRUED BED TAX	26,223	26,223
DUE TO MEDICAID	22,937	22,937
	49,160	49,160

OTHER NON-CURRENT ASSETS (PAGE 17, LINE 23)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM AFFILIATE	1,028,084	1,028,084
DUE FROM OTHERS	25,000	25,000
LOAN FEES		139,432
A/A ORGANIZATIONAL COSTS		(11,619)
	1,053,084	1,180,897

OTHER NON-CURRENT LIABILITIES (PAGE 17, LINE 43)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO OPCO		1,036,084
	-	1,036,084

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,432,201	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt**	1,023	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,433,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	611,766	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	(203,000)	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)**	$ 408,766	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,841,990	24 *

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,924,221	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,924,221	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,788	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,788	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	307,699	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 307,699	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,241,708	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,543,388	31
32	Health Care	3,606,567	32
33	General Administration	2,222,561	33
	B. Capital Expense		
34	Ownership	1,646,513	34
	C. Ancillary Expense		
35	Special Cost Centers	1,132,523	35
36	Provider Participation Fee	478,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,629,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	611,766	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 611,766	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,194,793	44
45	Private Pay - Net Inpatient Revenue	306,853	45
46	Medicare - Net Inpatient Revenue	2,076,128	46
47	Other-(specify) Hospice	180,730	47
48	Other-(specify) Commercial	165,717	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,924,221	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	**River View Rehab Center LLC**
FACILITY NUMBER	**0052795**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

DESCRIPTION	AMOUNT
MEDICAID W/O CO-INS	305,633
VENDING INCOME (ADJ PG 5A)	1,250
MISC INC (ADJ PG 5A)	696
MEDICAL RECORDS INCOME (ADJ PG 5A)	120
	307,699

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	1,760	2,072	$ 91,962	$ 44.38	1
2	Assistant Director of Nursing	1,904	2,088	76,263	36.52	2
3	Registered Nurses	34,694	37,830	1,236,015	32.67	3
4	Licensed Practical Nurses	8,385	9,104	250,753	27.54	4
5	CNAs & Orderlies	69,040	71,450	1,116,094	15.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,205	5,586	83,781	15.00	8
9	Activity Director	1,832	2,080	35,115	16.88	9
10	Activity Assistants	7,913	8,391	81,549	9.72	10
11	Social Service Workers	16,143	17,432	276,965	15.89	11
12	Dietician					12
13	Food Service Supervisor	3,655	4,089	68,039	16.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,650	23,339	259,773	11.13	15
16	Dishwashers					16
17	Maintenance Workers	9,215	9,915	128,890	13.00	17
18	Housekeepers	20,189	22,087	234,039	10.60	18
19	Laundry	6,846	7,373	76,681	10.40	19
20	Administrator	1,888	2,272	118,944	52.35	20
21	Assistant Administrator	1,912	2,000	76,700	38.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,647	7,297	78,360	10.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,535	4,061	55,415	13.65	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached					33
34	TOTAL (lines 1 - 33)	222,413	238,466	$ 4,345,338 *	$ 18.22	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	499	$ 23,461	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	174,000	10-03	38
39	Pharmacist Consultant	338	13,550	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant	51	2,572	11-03	44
45	Social Service Consultant	21	1,338	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	909	$ 234,120		49

C. CONTRACT NURSES

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

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arshad Rahman	Administrator	0.00%	$ 118,944
Pawn Thammarath	Asst. Admin	0.00%	76,700
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 195,644

B. Administrative - Other

Description	Amount
Consulting Fees - Premier HC & Financial Services	$ 667,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 667,000

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 8,877
Marcum LLP	Accounting	15,893
Mowery & Scoenfeld	Accounting	2,026
Aatrix	Electronic Forms Consulting	74
Midwest Time Recorders	Time Record Software	1,489
Reliable Health Systems	Data Processing	16,740
Creative Technologies	IT Support	7,200
Point Click Care	Data Processing	34,257
Streamline HR	HR Consulting	182
Zirmed	Data Processing	575
Experian	Computer Services	127
See Supplemental Schedule		16,695
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 104,135

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,717
Unemployment Compensation Insurance	28,710
FICA Taxes	321,228
Employee Health Insurance	100,339
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Expense	22,135
Holiday Expense	2,963
TOTAL (agree to Schedule V, line 22, col.8)	$ 561,092

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	28,055
Health Care Worker Background Check	6,654
(Indicate # of checks performed 665)	
Patient Background Checks	
Dues	16,433
License & Fees	4,841
Allocated From Premier HC & Financial	435
Allocated From Premier RE	11
Allocated From iCare Consulting	58
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,477

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,274
Allocated From Premier HC & Financial	966
Allocated From iCare Consulting	677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,917

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
OnShift	HR Consulting Software	$ 13,824
Ability Network	Data Processing	1,767
EON	Computer Services	382
Survey Monkey	Survey Services	5
Prospect Resources	Energy Consutling	600
Coordinated Benefits Co	Employee Benefits Consulting	117
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 16,695

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

River View Rehab Center
Detail of Legal Expense
12/31/2018

GL Account	Date	Vendor	Description of Service	Amount	Adjustment	Allowable
8380.6	11/13/2017	Neal Gerber & Eisenberg	Prior Period Legal Service	196.20	(196.20)	-
8380.6	12/19/2017	Neal Gerber & Eisenberg	Prior Period Legal Service	45.23	(45.23)	-
8380.6	7/30/2018	Neal Gerber & Eisenberg	Employment Matters	17.25		17.25
8380.6	1/25/2018	Meyer Magence	Prior Period Legal Service	225.00	(225.00)	-
8380.6	11/22/2017	SB2	Prior Period Legal Service	571.43	(571.43)	-
8380.6	12/12/2017	SB2	Prior Period Legal Service	214.29	(214.29)	-
8380.6	12/13/2017	SB2	Prior Period Legal Service	220.63	(220.63)	-
8380.6	12/31/2017	SB2	Prior Period Legal Service	571.42	(571.42)	-
8380.6	1/22/2018	SB2	Monthly PA Review	550.00	-	550.00
8380.6	1/2/2018	SB2	Monthly PA Review	192.36	-	192.36
8380.6	2/14/2018	SB2	Monthly PA Review	506.25	-	506.25
8380.6	3/1/2018	SB2	Monthly PA Review	187.50	-	187.50
8380.6	7/31/2018	Polsinelli	Managed Care Contracting	3,821.96	(508.32)	3,313.64
8380.6	10/31/2018	Polsinelli	Managed Care Contracting	1,207.60	-	1,207.60
8420.6	8/2/2018	Dykema	Organizational Documents	350.00	(350.00)	-
				8,877.12	(2,902.52)	5,974.60

Facility Name & ID Number River View Rehab Center LLC # 0052795 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. **ILCLTC- $32,866**

(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. $ **12,317** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **478,390**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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