

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

<p>I. IDPH License ID Number: <u>0052795</u></p> <p>Facility Name: <u>River View Rehab Center</u></p> <p>Address: <u>50 North Jane</u> <u>Elgin</u> <u>60123</u> <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847) 697-3750</u> Fax # <u>(847) 697-5385</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/1/2014</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ <u>05/04/2021</u> <i>* Subject to the attached Accountants' Consulting Report</i> (Date) (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ <u>05/04/2021</u> <i>* Subject to the attached Accountants' Consulting Report</i> (Date) (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number River View Rehab Center

0052795 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,573	3,573	8
9	SNF/PED					9
10	ICF	53,645	774	1,337	55,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,645	774	4,910	59,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.85%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 203 and days of care provided 3,573

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	377,882	36,308	19,191	433,381		433,381		433,381		1
2	Food Purchase		365,660		365,660		365,660	(48)	365,612		2
3	Housekeeping	300,937	85,411		386,348		386,348	4,561	390,909		3
4	Laundry	96,945	18,219	189	115,353		115,353		115,353		4
5	Heat and Other Utilities			185,781	185,781		185,781	(17,539)	168,242		5
6	Maintenance	80,585		124,361	204,946		204,946	(20,001)	184,945		6
7	Other (specify):*							2,459	2,459		7
8	TOTAL General Services	856,349	505,598	329,522	1,691,469		1,691,469	(30,568)	1,660,901		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,999,061	275,500	191,631	3,466,192		3,466,192	(118,614)	3,347,578		10
10a	Therapy	83,831			83,831		83,831		83,831		10a
11	Activities	124,463	2,224	1,179	127,866		127,866		127,866		11
12	Social Services	315,476	343	1,330	317,149		317,149		317,149		12
13	CNA Training										13
14	Program Transportation			28,349	28,349		28,349		28,349		14
15	Other (specify):*							6,114	6,114		15
16	TOTAL Health Care and Programs	3,522,831	278,067	236,889	4,037,787		4,037,787	(112,500)	3,925,287		16
	C. General Administration										
17	Administrative	206,917		305,333	512,250		512,250	(186,194)	326,056		17
18	Directors Fees										18
19	Professional Services			588,245	588,245	(1,340)	586,905	(468,603)	118,302		19
20	Dues, Fees, Subscriptions & Promotions			66,844	66,844		66,844	(20,198)	46,646		20
21	Clerical & General Office Expenses	150,898		322,170	473,068		473,068	(44,141)	428,927		21
22	Employee Benefits & Payroll Taxes			601,427	601,427		601,427		601,427		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,471	1,471		1,471	1,025	2,496		24
25	Other Admin. Staff Transportation			2,804	2,804		2,804	5,124	7,928		25
26	Insurance-Prop.Liab.Malpractice			402,744	402,744		402,744	4,725	407,469		26
27	Other (specify):*							59,829	59,829		27
28	TOTAL General Administration	357,815		2,291,038	2,648,853	(1,340)	2,647,513	(648,433)	1,999,080		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,736,995	783,665	2,857,449	8,378,109	(1,340)	8,376,769	(791,501)	7,585,268		29

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

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

Facility Name & ID Number

River View Rehab Center

#0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,119	20,119		20,119	610,048	630,167			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,088	5,088		5,088	755,492	760,580			32
33	Real Estate Taxes					1,340	1,340	120,577	121,917			33
34	Rent-Facility & Grounds			1,641,332	1,641,332		1,641,332	(1,641,332)				34
35	Rent-Equipment & Vehicles			4,584	4,584		4,584		4,584			35
36	Other (specify):*			45,000	45,000		45,000	105,476	150,476			36
37	TOTAL Ownership			1,716,123	1,716,123	1,340	1,717,463	(49,739)	1,667,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	36	95,826	770,331	866,193		866,193		866,193			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			497,627	497,627		497,627		497,627			42
43	Other (specify):*			22,921	22,921		22,921	(22,921)	(0)			43
44	TOTAL Special Cost Centers	36	95,826	1,290,879	1,386,741		1,386,741	(22,921)	1,363,820			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,737,031	879,491	5,864,451	11,480,973		11,480,973	(864,161)	10,616,812			45

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	610,048	30		9
10	Interest and Other Investment Income	(29,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	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	(1,401)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(157,165)	21		24
25	Fund Raising, Advertising and Promotional	(1,681)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,689)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(393,014)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,123)		\$	30

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	2	
		Amount	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)	(858,038)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (858,038)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (864,161)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

River View Rehab Center

ID# 0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (17,802)	21	1
2	Sequestration Expense	(76,875)	21	2
3	Miscellaneous Income	(16,397)	21	3
4	Marketing Expense	(1,321)	43	4
5	Indemnity	(45,000)	36	5
6	Building Co. - Licenses and Permits	(77)	20	6
7	Building Co. - Professional Fees	(2,800)	19	7
8	Building Co. - Closing Costs	(170,076)	21	8
9	Additional R&M	334	06	9
10	Capitalized R&M	(12,047)	06	10
11	PAC Dues	(18,716)	20	11
12	Prior Period Miscellaneous Expense	(1,476)	21	12
13	Prior Period Professional Fees	(15,971)	19	13
14	Non-Allowable Legal	(14,790)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	(393,014)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River View Rehab Center# 0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(48)											(48)	2
3	Housekeeping			4,561									4,561	3
4	Laundry													4
5	Heat and Other Utilities	(20,483)		2,944									(17,539)	5
6	Maintenance	(11,713)		3,339		(11,627)							(20,001)	6
7	Other (specify):*					2,459							2,459	7
8	TOTAL General Services	(32,244)		10,844		(9,168)							(30,568)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(118,614)							(118,614)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,114							6,114	15
16	TOTAL Health Care and Programs					(112,500)							(112,500)	16
	C. General Administration													
17	Administrative			(219,415)		33,221							(186,194)	17
18	Directors Fees													18
19	Professional Services	(33,560)	2,800	(442,081)	1,770	2,468							(468,603)	19
20	Fees, Subscriptions & Promotions	(20,474)	77	122		77							(20,198)	20
21	Clerical & General Office Expenses	(453,882)	168,576	193,273		47,891							(44,141)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			868		157							1,025	24
25	Other Admin. Staff Transportation					5,124							5,124	25
26	Insurance-Prop.Liab.Malpractice			1,877		2,848							4,725	26
27	Other (specify):*			45,296		14,533							59,829	27
28	TOTAL General Administration	(507,916)	171,453	(420,060)	1,770	106,319							(648,433)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(540,160)	171,453	(409,216)	1,770	(15,349)							(791,501)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River View Rehab Center # 0052795 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	610,048											610,048	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(29,690)	776,412	6	2,526		6,238						755,492	32
33	Real Estate Taxes		109,155		2,907		8,515						120,577	33
34	Rent-Facility & Grounds		(1,641,332)	33,228	(14,393)		(18,835)						(1,641,332)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(45,000)	150,476										105,476	36
37	TOTAL Ownership	535,358	(605,289)	33,234	(8,960)		(4,082)						(49,739)	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):*	(1,321)				(21,600)							(22,921)	43
44	TOTAL Special Cost Centers	(1,321)				(21,600)							(22,921)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,123)	(433,836)	(375,981)	(7,190)	(36,949)	(4,082)						(864,161)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,641,332	River View Rehab Center Realty LLC		\$	\$ (1,641,332)	1
2	V	21 Misc. Income	1,500	River View Rehab Center Realty LLC			(1,500)	2
3	V	20 Licenses and Permits		River View Rehab Center Realty LLC		77	77	3
4	V	32 Interest		River View Rehab Center Realty LLC		776,412	776,412	4
5	V	36 MIP		River View Rehab Center Realty LLC		150,476	150,476	5
6	V	19 Professional Fees		River View Rehab Center Realty LLC		2,800	2,800	6
7	V	33 Real Estate Taxes		River View Rehab Center Realty LLC		109,155	109,155	7
8	V	21 Closing Costs		River View Rehab Center Realty LLC		170,076	170,076	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,642,832			\$ 1,208,996	\$ * (433,836)	14

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

Facility Name & ID Number

River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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 & Financial	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 Services	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	iCare Health Services -			5
6	Howard Wengrow	7.27%	Pearl Pavilion	Freeport	Incorporated Cell	Burlington, VT	Insurance	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	0.50%						13
14	Rivky Kaminsky	0.50%						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

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		\$ 4,561	\$ 4,561
16	V	5 UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		2,944	2,944
17	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,339	3,339
18	V	17 ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		85,918	85,918
19	V	19 PROFESSIONAL FEES	446,667	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4,586	(442,081)
20	V	20 DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		122	122
21	V	21 CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		10,824	10,824
22	V	21 CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		182,449	182,449
23	V	24 SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		868	868
24	V	26 INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,877	1,877
25	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		45,296	45,296
26	V	32 INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		6	6
27	V	34 RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		33,228	33,228
28	V	17 CONSULTING FEES	305,333	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(305,333)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 752,000			\$ 376,019	\$ * (375,981)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		1,770	1,770	16
17	V	20 LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30 DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32 INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		2,526	2,526	19
20	V	33 REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		2,907	2,907	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	14,393	PREMIER HEALTHCARE REALTY, LLC			(14,393)	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		\$ 14,393			\$ 7,203	\$ * (7,190)	39

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINTENANCE	\$ 32,400	ICARE CONSULTING SERVICES LLC		\$ 20,773	\$ (11,627)
16	V	7 R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		2,459	2,459
17	V	10 NURSING SALARIES	166,700	ICARE CONSULTING SERVICES LLC		48,086	(118,614)
18	V	15 EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		6,114	6,114
19	V	17 ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		33,221	33,221
20	V	19 PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		2,468	2,468
21	V	20 DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		77	77
22	V	21 CLERICAL AND GENERAL	44,500	ICARE CONSULTING SERVICES LLC		3,001	(41,499)
23	V	21 CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		89,390	89,390
24	V	24 SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		157	157
25	V	25 AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		5,124	5,124
26	V	26 INSURANCE		ICARE CONSULTING SERVICES LLC		2,848	2,848
27	V	27 EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		14,533	14,533
28	V						
29	V	43 MARKETING CONSULTANT	21,600				(21,600)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 265,200			\$ 228,251	\$ * (36,949)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V	19 PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20 LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30 DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32 INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		6,238	6,238	19
20	V	33 REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		8,515	8,515	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	18,835	8131 MONTICELLO REALTY, LLC			(18,835)	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		\$ 18,835			\$ 14,753	\$ * (4,082)	39

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 INSURANCE	\$ 358,853	ICARE HEALTH SERVICES INCORPORATED CELL		\$ 358,853	\$	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		\$ 358,853			\$ 358,853	\$ *	39

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Shimon Webster	Member	Administrative	21.39%	See Attached	6.62	16.54%	Alloc Salary	\$ 23,037	17-7	1	
2	Yeruchom Levovitz	Member	Administrative	19.91%	See Attached	6.62	16.54%	Alloc Salary	21,522	17-7	2	
3	Kevin Chankin	Member	Administrative	2.46%	See Attached	6.62	16.54%	Alloc Salary	41,359	17-7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 85,918		13	

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 PREMIER HEALTHCARE & FIN. SVCS, INC.
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	\$ 27,572	\$ 59,329	\$ 4,561	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798	59,329	2,944	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184	59,329	3,339	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	85,918	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719	59,329	4,586	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738	59,329	122	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	10,824	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850	59,329	182,449	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249	59,329	868	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347	59,329	1,877	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803	59,329	45,296	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39	59,329	6	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851	59,329	33,228	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					\$ 2,272,926	\$ 1,622,196	\$ 376,019	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 PREMIER HEALTHCARE REALTY, LLC
 Street Address 8153 LAWNSDALE
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 945-6107

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700	59,329	1,770	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8		59,329		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8		59,329		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267	59,329	2,526	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574	59,329	2,907	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					\$ 43,541	\$	\$ 7,203	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 ICARE CONSULTING SERVICES LLC
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 945-6107

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	\$ 145,610	\$ 145,409	246,800	\$ 20,773	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		246,800	2,459	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	246,800	48,086	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		246,800	6,114	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	246,800	33,221	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		246,800	2,468	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		246,800	77	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		246,800	3,001	8
9	21	CLERICAL & GENERAL WAGI	CONSULTING FEES	1,730,000	8	626,600	626,600	246,800	89,390	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		246,800	157	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		246,800	5,124	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		246,800	2,848	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		246,800	14,533	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					\$ 1,599,973	\$ 1,341,950		\$ 228,251	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 8131 MONTICELLO REALTY, LLC
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 945-6107

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8		59,329		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8		59,329		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8		59,329		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708	59,329	6,238	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468	59,329	8,515	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 89,176	\$		\$ 14,753	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 ICARE HEALTH SERVICES INCORP. CELL
 Street Address 30 MAIN STREET, SUITE 330
 City / State / Zip Code BURLINGTON, VERMONT 05401
 Phone Number ()
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 358,853	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				\$	\$		\$ 358,853	25

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number River View Rehab Center

0052795 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Facility Name & ID Number

River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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 Payable			\$	\$ 15,021,703			\$	776,412	1					
2													2					
3													3					
4													4					
5													5					
Working Capital																		
6	First Midwest Bank		X	Line of Credit								5,088	6					
7	Allocated from Premier HC		X									6	7					
8	See Supplemental Schedule											8,764	8					
9	TOTAL Facility Related						\$	\$ 15,021,703			\$	790,270	9					
B. Non-Facility Related*																		
10	Interest Income		X									(29,690)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(29,690)	14					
15	TOTALS (line 9+line14)						\$	\$ 15,021,703			\$	760,580	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 150,476 Line # 36

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.		\$	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.)		\$	120,577 2
3. Under or (over) accrual (line 2 minus line 1).		\$	120,577 3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	1,340 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.		\$	121,917 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	120,771	8
	2016	121,181	9
	2017	115,892	10
	2018	110,767	11
	2019	109,155	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Facility does not accrue real estate tax
Allocated from Premier RE = \$2,907
Allocated from 8131 Monticello = \$8,515

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River View Rehab Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052795

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-15-304-015</u>	<u>Long Term Care Property</u>	\$ <u>109,155.12</u>	\$ <u>109,155.12</u>
2. <u>10-23-324-047-0000</u>	<u>Allocated from Premier RE</u>	\$ <u>34,381.62</u>	\$ <u>5,687.90</u>
3. <u>10-23-325-045-0000</u>	<u>Allocated from 8131 Monticello</u>	\$ <u>51,467.63</u>	\$ <u>8,514.51</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>195,004.37</u></u>	\$ <u><u>123,357.53</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River View Rehab Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052795

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number River View Rehab Center

0052795 Report Period Beginning:

01/01/20 Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Rows include Facility, see attached related parties allocation, and TOTALS.

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203	2017	1972	\$ 13,126,827	\$	35	\$ 375,052	\$ 375,052	\$ 1,500,208
5									
6									
7									
8									
Improvement Type**									
9	Various		2014	2,800		20	140	140	875
10	Various		2015	30,000		20	1,500	1,500	9,000
11	Various		2016	41,615		20	2,081	2,081	8,905
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68			322,575		11,733	11,733	72,930	68		
69				20,119		(20,119)		69		
70		\$	13,523,817	\$	20,119	\$	370,387	\$	1,591,918	70

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,523,817	\$ 20,119		\$ 390,506	\$ 370,387	\$ 1,591,918	1
2	New Call Lights In Hallway 2200, 2300, Lobby	2017	9,682		20	484	484	1,856	2
3	Breakers For Generator	2017	6,500		20	325	325	1,246	3
4	Generator - Drawings	2017	3,500		20	175	175	656	4
5	New Car Sill For Front Elevator	2017	4,200		20	210	210	665	5
6	Electircal-Hvac & Light Fixtures-1St Floor/Generator/Driveway	2018	6,500		20	325	325	921	6
7	Laundry Room-5 Ton Rtu Unit W/ Gas & Electric Connections	2018	7,650		20	383	383	1,021	7
8	Repair Of Circulation And Piping For Common Areas	2018	2,904		20	145	145	435	8
9	Walk-In Freezer Condensor	2019	6,850		20	343	343	429	9
10	New Display Sign	2019	10,335		20	517	517	560	10
11	Bathroom Faucets, Grab Bars	2020	9,952		20	498	498	498	11
12	Domestic Hot Water Mixing Valve Repair	2020	3,460		20	173	173	173	12
13	Sealtcoat & Stripe Main Parking Area, Install Handicap Sign	2020	2,575		20	129	129	129	13
14	Electrical - Install New 100Amp 3 Pole Panel For Critical Circuits	2020	5,300		20	265	265	265	14
15	Water Meter Valve Replacement	2020	2,747		20	137	137	137	15
16	Roof Repair - Patching, Reseal Caulk, Pitch Pans, Termination M	2020	4,000		20	200	200	200	16
17	227 Door Levers, P-Trap Cover	2020	9,974		20	499	499	499	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)		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608	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		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608	34

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

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Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608	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		\$ 13,619,947	\$ 20,119		\$ 395,313	\$ 375,194	\$ 1,601,608	34

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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.

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	61,609		20	1,760	1,760	15,987	3
4	Allocated Premiere Healthcare Realty, LLC	2012	7,844		20	224	224	2,017	4
5	Allocated from 8131 N. Monticello	2019	135,697		20	3,877	3,877	7,754	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier HC & Financial Services	2012	1,398		20	70	70	630	9
10	Allocated from Premier HC & Financial Services	2016	3,276		20	164	164	819	10
11									11
12	Allocated Premiere Healthcare Realty, LLC	2011	109,575		20	5,479	5,479	44,294	12
13	Allocated Premiere Healthcare Realty, LLC	2012	3,176		20	159	159	1,429	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)		\$ 322,575	\$		\$ 11,733	\$ 11,733	\$ 72,930	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 322,575	\$		\$ 11,733	\$ 11,733	\$ 72,930	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)	\$ 322,575	\$		\$ 11,733	\$ 11,733	\$ 72,930	34

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	\$ 2,332,482	\$	\$ 233,248	\$ 233,248	10	\$ 949,281	71
72	Current Year Purchases	26,255		1,606	1,606	10	1,606	72
73	Fully Depreciated Assets	8,384				10	8,384	73
74								74
75	TOTALS	\$ 2,367,121	\$	\$ 234,854	\$ 234,854		\$ 959,271	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)	\$ 16,846,915	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,119	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 630,167	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 610,048	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,560,879	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,584 Description: See Attached

(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

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.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 320,615							\$ 320,615	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					61,069							61,069	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					381,684							381,684	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescripts							78,589					78,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Attached</u>				36			6,963		17,237					24,236	13
14	TOTAL				\$ 36			\$ 770,331		\$ 95,826					\$ 866,193	14

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending:

12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,984,600	\$ 3,132,085	1
2	Cash-Patient Deposits	6,300	6,300	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	559,134	559,134	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	469,497	469,497	6
7	Other Prepaid Expenses	30,824	30,824	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	34,992	34,992	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,085,347	\$ 4,232,832	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	136,764	696,532	15
16	Equipment, at Historical Cost	50,008	3,007,311	16
17	Accumulated Depreciation (book methods)	(83,181)	(2,837,154)	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): <u>See Attached</u>	1,028,927	381,012	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,132,518	\$ 14,051,656	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,217,865	\$ 18,284,488	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 484,896	\$ 484,896	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	366,600	366,600	30
31	Accrued Taxes Payable (excluding real estate taxes)	217,320	217,320	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached</u>	1,291,559	1,291,559	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,360,375	\$ 2,360,375	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,021,703	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached</u>	33,673	33,673	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 33,673	\$ 15,055,376	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,394,048	\$ 17,415,751	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,823,817	\$ 868,737	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,217,865	\$ 18,284,488	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,855,964	1
2	Restatements (describe):		2
3	Management Fees	92,100	3
4	Bookkeeping Fees	(202,100)	4
5	Sequestration Expense/Other	(3,560)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,742,404	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,081,413	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)	\$ 1,081,413	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)	\$ 2,823,817	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning: 01/01/20

Ending: 12/31/20

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,296,079	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,296,079	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	575,173	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 575,173	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***	29,690	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,690	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,661,444	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,661,444	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,562,386	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,691,469	31
32	Health Care	4,037,787	32
33	General Administration	2,648,853	33
B. Capital Expense			
34	Ownership	1,716,123	34
C. Ancillary Expense			
35	Special Cost Centers	889,114	35
36	Provider Participation Fee	497,627	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,480,973	40
41	Income before Income Taxes (line 30 minus line 40)**	1,081,413	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,081,413	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,769,573	44
45	Private Pay - Net Inpatient Revenue	147,767	45
46	Medicare - Net Inpatient Revenue	2,080,140	46
47	Other-(specify) <u>Hospice</u>	187,771	47
48	Other-(specify) <u>Insurance</u>	110,828	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,296,079	49

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

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

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

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

Facility Name & ID Number River View Rehab Center

0052795

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,928	2,068	\$ 107,685	\$ 52.07	1
2	Assistant Director of Nursing	1,971	2,113	87,193	41.27	2
3	Registered Nurses	39,022	40,922	1,314,319	32.12	3
4	Licensed Practical Nurses	9,292	9,965	272,715	27.37	4
5	CNAs & Orderlies	79,634	85,394	1,155,570	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,393	4,711	83,831	17.79	8
9	Activity Director	2,259	2,423	45,159	18.64	9
10	Activity Assistants	7,145	7,661	79,304	10.35	10
11	Social Service Workers	14,732	15,798	306,905	19.43	11
12	Dietician					12
13	Food Service Supervisor	4,851	5,202	96,919	18.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,406	22,954	280,963	12.24	15
16	Dishwashers					16
17	Maintenance Workers	3,697	3,964	80,585	20.33	17
18	Housekeepers	24,745	26,535	300,937	11.34	18
19	Laundry	7,965	8,542	96,945	11.35	19
20	Administrator	2,009	2,154	127,060	58.99	20
21	Assistant Administrator	1,730	1,855	79,857	43.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,158	8,748	150,898	17.25	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	3,895	4,177	61,579	14.74	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	694	745	8,607	11.55	33
34	TOTAL (lines 1 - 33)	239,526	255,931	\$ 4,737,031 *	\$ 18.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	408	\$ 19,191	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	169,700	10-03	38
39	Pharmacist Consultant	317	12,680	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	Monthly	1,179	11-03	44
45	Social Service Consultant	21	1,330	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	746	\$ 222,880		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	97	\$ 4,851	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	97	\$ 4,851		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Arshad Rahman	Administrator	0	\$ 127,060	Workers' Compensation Insurance	\$ 76,583	IDPH License Fee	\$	
Pawn Thammarath	Asst. Administrator	0	79,857	Unemployment Compensation Insurance	19,602	Advertising: Employee Recruitment	10,491	
				FICA Taxes	362,383	Health Care Worker Background Check (Indicate # of checks performed <u>729</u>)	7,290	
				Employee Health Insurance	67,028	Patient Background Checks		
				Employee Meals		Dues HCCI	18,716	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	9,950	
				Other Employee Expense	73,012			
				Holiday Expense	2,820			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 206,917	TOTAL (agree to Schedule V, line 22, col.8)		\$ 601,428	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Consulting Fees - Premier HC & Financial Services			\$ 305,333				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 305,333				In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount					1,471
Marcum LLP	Accounting		\$ 35,995				See Supplemental Schedule	1,025
Premier Healthcare	Bookkeeping Fees		446,667				Entertainment Expense	()
Point Click Care	Data Processing		38,997				(agree to Sch. V, line 24, col. 8)	
Reliable Health Care	Data Processing		17,140				TOTAL	\$ 2,496
Creative Technologies	IT Support		12,964					
EON Applications	Computer Services		978					
Ability Network	Medicare Billing		2,063					
OnShift	HR Consulting		13,824					
Zirmed	Data Processing		640					
Prospect Resources	Energy Consulting		1,300					
See Attached	Legal		16,878					
See Supplemental Schedule			800					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 588,246					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number River View Rehab Center# 0052795Report Period Beginning: 01/01/20Ending: 12/31/20**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. HCCI - \$37,432
- (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. \$ 8,046 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? 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. \$ 497,627
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? 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.