FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0052563

Facility Name: RIVER NORTH OF BRADLEY HEALTH & REHAB

Address: 650 NORTH KINZIE (Number) BRADLEY (City) 60915 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 933-1666 **Fax #** (815) 933-9866

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2013

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AARON MAUER
(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	67	Skilled (SNF)	67	24,455	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			9,330	9,330	8
9	SNF/PED					9
10	ICF	20,742	3,123		23,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,742	3,123	9,330	33,195	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.79%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 12/01/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 67 and days of care provided 6,394

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		4,318	475,148	479,466		479,466		479,466			1
2	Food Purchase		3,444		3,444		3,444	(63)	3,381			2
3	Housekeeping		1,761	169,200	170,961		170,961		170,961			3
4	Laundry		3,442	112,800	116,242		116,242		116,242			4
5	Heat and Other Utilities			105,431	105,431		105,431		105,431			5
6	Maintenance	81,063	52,112	12,125	145,300		145,300	1,711	147,011			6
7	Other (specify):*			13,885	13,885		13,885		13,885			7
8	TOTAL General Services	81,063	65,077	888,589	1,034,729		1,034,729	1,648	1,036,377			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	1,840,493	196,367	83,981	2,120,841		2,120,841	22,183	2,143,024			10
10a	Therapy											10a
11	Activities	102,953	7,713		110,666		110,666		110,666			11
12	Social Services	33,299		1,764	35,063		35,063		35,063			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,288	9,288			15
16	TOTAL Health Care and Programs	1,976,745	204,080	92,345	2,273,170		2,273,170	31,471	2,304,641			16
	C. General Administration											
17	Administrative	101,444		320,000	421,444		421,444	(73,636)	347,808			17
18	Directors Fees											18
19	Professional Services			248,183	248,183		248,183	(56,682)	191,501			19
20	Dues, Fees, Subscriptions & Promotions			61,344	61,344		61,344	(26,276)	35,068			20
21	Clerical & General Office Expenses	224,390	33,688	164,404	422,482		422,482	(67,029)	355,453			21
22	Employee Benefits & Payroll Taxes			431,174	431,174		431,174		431,174			22
23	Inservice Training & Education			3,998	3,998		3,998		3,998			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,103	18,103		18,103	1,721	19,824			25
26	Insurance-Prop.Liab.Malpractice			129,342	129,342		129,342		129,342			26
27	Other (specify):*			102,799	102,799		102,799	(78,159)	24,640			27
28	TOTAL General Administration	325,834	33,688	1,479,347	1,838,869		1,838,869	(300,061)	1,538,808			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,383,642	302,845	2,460,281	5,146,768		5,146,768	(266,942)	4,879,826			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#: RIVER NORTH OF BRADLEY HEALTH & REHAB **#0052563** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICES DIETARY		475,148	475,148
3	**HOUSEKEEPING**			
	CONTRACTED BUILDING MAINT.		169,200	
				169,200
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICES-LAUNDRY		112,800	112,800
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		0	
	WATER		42,701	
	CABLE TV - LOBBY		10,292	
	UNTILITIES		52,438	105,431
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,060	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,065	
	FIRE SERVICE		0	
				12,125
7	**OTHER**			
	SCAVENGER		13,885	
	SECURITY SERVICE		0	
				13,885
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,600	6,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	12,981	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	71,000	
				83,981
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,764	
				1,764
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB **#0052563** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	320,000	320,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	136,844	
	ADMINISTRATIVE CONSULTANTS	XIX C	71,000	
	PROFESSIONAL FEES	XIX C	40,339	
				248,183
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,290	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	16,020	
	CONTRIBUTIONS	VI 20 XIX F	1,535	
	DUES & SUBSCRIPTIONS	XIX F	12,036	
	LICENSES & PERMITS	XIX F	5,395	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,600	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,468	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				61,344
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		16,891	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		120,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27,513	
	MESSENGER SERVICE		0	
				164,404

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	180,713	
	UNEMPLOYMENT COMPENSATION	XIX D	29,162	
	WORKERS COMPENSATION INSURANC	XIX D	79,237	
	HOSPITALIZATION INSURANCE	XIX D	129,512	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,550	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				431,174
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,998	
				3,998
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,103	
				18,103
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		129,342	
				129,342
27	**OTHER**			
	BAD DEBTS	VI 24	102,799	
				102,799

GRAND TOTAL COLUMN 3 OTHER **2,460,281**

RIVER NORTH OF BRADLEY HEALTH & REHAB
SCHEDULES
12/31/2017

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	3,444
LESS SALES TAX	(63)
NET FOOD	3,381
TOTAL PATIENT CENSUS	33,195
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	99,585
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	24,455
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	99,585
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	99,585
NET FOOD	3,381
DIVIDE TOTAL MEALS/YEAR	99,585
COST PER MEAL	0.03
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB #0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			153,594	153,594		153,594	162,344	315,938			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,114	63,114		63,114	318,909	382,023			32
33	Real Estate Taxes							100,051	100,051			33
34	Rent-Facility & Grounds			562,498	562,498		562,498	(554,306)	8,192			34
35	Rent-Equipment & Vehicles			100,418	100,418		100,418	(37,100)	63,318			35
36	Other (specify):* **amort- comp soft**			1,490	1,490		1,490	22,193	23,683			36
37	**TOTAL Ownership**			881,114	881,114		881,114	12,091	893,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		275,878	833,396	1,109,274		1,109,274		1,109,274			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,015	250,015		250,015		250,015			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		275,878	1,083,411	1,359,289		1,359,289		1,359,289			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,383,642	578,723	4,424,806	7,387,171		7,387,171	(254,851)	7,132,320			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 NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(63,838)	30		9
10	Interest and Other Investment Income	(1,631)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(6,135)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(102,799)	27		24
25	Fund Raising, Advertising and Promotional	(20,290)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(43,008)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (237,764)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,087)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,087)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (254,851)		37

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

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

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

STATE OF ILLINOIS

RIVER NORTH OF BRADLEY HEALTH & REHAB

ID# 0052563

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AUTO LEASE	$ (43,008)	35	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(43,008)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB **#** 0052563 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(63)	0	0	0	0	0	0	0	0	0	0	(63)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	1,711	0	0	0	0	0	0	0	0	1,711	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(63)	0	1,711	0	0	0	0	0	0	0	0	1,648	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	22,183	0	0	0	0	0	0	0	0	22,183	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	9,288	0	0	0	0	0	0	0	0	9,288	15
16	**TOTAL Health Care and Programs**	0	0	31,471	0	0	0	0	0	0	0	0	31,471	16
	C. General Administration													
17	Administrative	0	(140,000)	66,364	0	0	0	0	0	0	0	0	(73,636)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,245	(61,927)	0	0	0	0	0	0	0	0	(56,682)	19
20	Fees, Subscriptions & Promotions	(26,425)	0	149	0	0	0	0	0	0	0	0	(26,276)	20
21	Clerical & General Office Expenses	0	3,951	(70,980)	0	0	0	0	0	0	0	0	(67,029)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,721	0	0	0	0	0	0	0	0	1,721	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(102,799)	0	24,640	0	0	0	0	0	0	0	0	(78,159)	27
28	**TOTAL General Administration**	(129,224)	(130,804)	(40,033)	0	0	0	0	0	0	0	0	(300,061)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(129,287)	(130,804)	(6,851)	0	0	0	0	0	0	0	0	(266,942)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(63,838)	226,182	0	0	0	0	0	0	0	0	0	162,344	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,631)	320,540	0	0	0	0	0	0	0	0	0	318,909	32
33	Real Estate Taxes	0	100,051	0	0	0	0	0	0	0	0	0	100,051	33
34	Rent-Facility & Grounds	0	(562,498)	8,192	0	0	0	0	0	0	0	0	(554,306)	34
35	Rent-Equipment & Vehicles	(43,008)	0	5,908	0	0	0	0	0	0	0	0	(37,100)	35
36	Other (specify):*	0	22,193	0	0	0	0	0	0	0	0	0	22,193	36
37	**TOTAL Ownership**	(108,477)	106,468	14,100	0	0	0	0	0	0	0	0	12,091	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(237,764)	(24,336)	7,249	0	0	0	0	0	0	0	0	(254,851)	45

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 562,498	River North Building, LLC		$	$ (562,498)	1
2	V	17	Management fees	140,000	River North Building, LLC			(140,000)	2
3	V	32	Interest		River North Building, LLC		320,540	320,540	3
4	V	30	Depreciation Expense		River North Building, LLC		226,182	226,182	4
5	V	21	State Replacement Tax		River North Building, LLC		3,951	3,951	5
6	V	19	Professional Fees		River North Building, LLC		5,245	5,245	6
7	V	36	Amortization Cost		River North Building, LLC		22,193	22,193	7
8	V	33	Real Estate Tax		River North Building, LLC		100,051	100,051	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 702,498			$ 678,162	$ * (24,336)	14

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 180,000	GREAT LAKES HEALTHCARE GROUP		$	$ (180,000)	15
16	V	21	OUTSIDE CLERICAL	120,000	GREAT LAKES HEALTHCARE GROUP			(120,000)	16
17	V	19	ADMINISTRATIVE CONSULTANT	71,000	GREAT LAKES HEALTHCARE GROUP			(71,000)	17
18	V	6	CLEANING SERVICE		GREAT LAKES HEALTHCARE GROUP		1,711	1,711	18
19	V	19	PROFESSIONAL FEES		GREAT LAKES HEALTHCARE GROUP		9,073	9,073	19
20	V	20	LICENSES		GREAT LAKES HEALTHCARE GROUP		149	149	20
21	V	21	CLERICAL AND OFFICE EXP		GREAT LAKES HEALTHCARE GROUP		12,533	12,533	21
22	V	25	AUTO EXPENSE		GREAT LAKES HEALTHCARE GROUP		1,721	1,721	22
23	V	34	OFFICE RENT		GREAT LAKES HEALTHCARE GROUP		8,192	8,192	23
24	V	35	AUTO LEASE		GREAT LAKES HEALTHCARE GROUP		5,488	5,488	24
25	V	35	EQUIPMENT RENTAL		GREAT LAKES HEALTHCARE GROUP		420	420	25
26	V	10	NURSE CONS. SAL- A CASS		GREAT LAKES HEALTHCARE GROUP		75,183	75,183	26
27	V	10	NURSE CONS. SAL- J HOPP		GREAT LAKES HEALTHCARE GROUP		18,000	18,000	27
28	V	15	EMPLOYEE BENEFITS		GREAT LAKES HEALTHCARE GROUP		9,288	9,288	28
29	V	21	CLERICAL SALARIES		GREAT LAKES HEALTHCARE GROUP		36,084	36,084	29
30	V	21	CLERICAL SALARIES- REL		GREAT LAKES HEALTHCARE GROUP		403	403	30
31	V	27	EMPLOYEE BENEFITS		GREAT LAKES HEALTHCARE GROUP		4,277	4,277	31
32	V	17	ADMINISTRATIVE- B FRIEDMAN		GREAT LAKES HEALTHCARE GROUP		150,000	150,000	32
33	V	27	EMPLOYEE BENEFITS		GREAT LAKES HEALTHCARE GROUP		12,398	12,398	33
34	V	17	CEO- E MARYLES		GREAT LAKES HEALTHCARE GROUP		55,065	55,065	34
35	V	17	CFO- A MAUER		GREAT LAKES HEALTHCARE GROUP		41,299	41,299	35
36	V	27	EMPLOYEE BENEFITS		GREAT LAKES HEALTHCARE GROUP		7,965	7,965	36
37	V	10	NURSING CONSULTANT	71,000	GREAT LAKES HEALTHCARE GROUP			(71,000)	37
38	V								38
39	Total			$ 442,000			$ 449,249	$ * 7,249	39

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	BEN FRIEDMAN	30	BRADLEY	BRADLEY				1
2	ELI LATINIK	4	GROSS POINTE MANOR LLC	NILES	Great Lakes			2
3	JONATHAN AARON	4	OTTAWA PAVILION LTD	OTTAWA	Healthcare Group	SKOKIE	MANAGEMENT	3
4	ILANA TELLER	7	PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5	FRED AARON	5	STERLING PAVILION LTD	STERLING	River North Building	BRADLEY	REAL ESTATE	5
6	ESTHER MARYLES	30	WILLOW CREST NURSING PAVILION	SANDWICH				6
7	CHANI MAUER	10	WATERFRONT TERRACE INC	CHICAGO				7
8	MARSHALL & GILA MAUER	10	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9			WOODBRIDGE NURSING PAVILION LTD	CHICAGO				9
10			WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11			WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12			BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW				12
13			SELECT POST ACUTE CARE LLC	EUREKA				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 NORTH OF BRADLEY HEALTH & # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	MEMBER	Administrative	0.10	See Attached	2	20.00	INTEREST	$ 4,330	32-3	1
2											2
3											3
4	Esther Maryles	MEMBER	Clerical	0.30	See Attached	4	20.00	SALARY	55,065	17-7	4
5	Benjamin Friedman	MEMBER	Administrative	0.30	See Attached	30	75.00	SALARY	150,000	17-7	5
6								SALARY	403	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 209,798		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 NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: GREAT LAKES HEALTHCARE GROUP
Street Address: 3413 MADISON STREET
City / State / Zip Code: SKOKIE, ILL 60076
Phone Number: (847)902-9586
Fax Number: (847)376-3554

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	CLEANING SERVICE	PATIENT DAYS	120,566	5	$ 6,214	$	33,195	$ 1,711	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	120,566	5	32,954		33,195	9,073	2
3	20	LICENSES	PATIENT DAYS	120,566	5	540		33,195	149	3
4	21	CLERICAL AND OFFICE EXP	PATIENT DAYS	120,566	5	45,521		33,195	12,533	4
5	25	AUTO EXPENSE	PATIENT DAYS	120,566	5	6,251		33,195	1,721	5
6	34	OFFICE RENT	PATIENT DAYS	120,566	5	29,752		33,195	8,192	6
7	35	AUTO LEASE	PATIENT DAYS	120,566	5	19,933		33,195	5,488	7
8	35	EQUIPMENT RENTAL	PATIENT DAYS	120,566	5	1,524		33,195	420	8
9	10	NURSE CONS. SAL- A CASS	WGHTD AVG HOURS	40	5	120,292	120,292	25	75,183	9
10	10	NURSE CONS. SAL- J HOPP	DIRECT COST	1	1	18,000	18,000	1	18,000	10
11	15	EMPLOYEE BENEFITS	WGHTD AVG HOURS	80	5	11,431		65	9,288	11
12	21	CLERICAL SALARIES	PATIENT DAYS	120,566	5	131,058	131,058	33,195	36,084	12
13	21	CLERICAL SALARIES- REL	PATIENT DAYS	120,566	5	1,464	1,464	33,195	403	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	120,566	5	15,533		33,195	4,277	14
15	17	ADMINISTRATIVE- B FRIEDM	WGHTD AVG HOURS	40	5	200,000	200,000	30	150,000	15
16	27	EMPLOYEE BENEFITS	WGHTD AVG HOURS	40	5	16,531		30	12,398	16
17	17	CEO- E MARYLES	PATIENT DAYS	120,566	5	200,000	200,000	33,195	55,065	17
18	17	CFO- A MAUER	PATIENT DAYS	120,566	5	150,000	150,000	33,195	41,299	18
19	27	EMPLOYEE BENEFITS	PATIENT DAYS	120,566	5	28,930		33,195	7,965	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,035,928	$ 820,814		$ 449,249	25

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB FINANCIAL		X	MORTGAGE	INT ONLY	6/15/15	$ 7,400,000	$ 7,400,000	06/05/20	3.2510	$ 301,530	1
2	MB FINANCIAL		X	WORKING CAPITAL	INT ONLY	6/15/15	1,500,000	1,500,000	06/05/20	1.2500	19,010	2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURES BANK										9,780	6
7	MARSHALL MAUER	X									4,330	7
8	MB FINANCIAL		X	LINE OF CREDIT	INTEREST			875,000	REVOLVE		49,004	8
9	TOTAL Facility Related						$ 8,900,000	$ 9,775,000			$ 383,654	9
	B. Non-Facility Related*											
10	IRS,IDR,ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,900,000	$ 9,775,000			$ 383,654	15

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	102,000	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.)	$	100,051	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,949)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	102,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	100,051	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013	76,872	9
2014	79,447	10
2015	100,455	11
2016	100,051	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~102% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER NORTH OF BRADLEY HEALTH & REHAB COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0052563

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-21-300-004	NURSING HOME	$ 100,051.00	$ 100,051.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 100,051.00	$ 100,051.00

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 X 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,063 B. General Construction Type: Exterior _____ Frame brick Number of Stories 1

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

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

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

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

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

N/A

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 250,000	1
2					2
3	TOTALS			$ 250,000	3

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2015	1963	$ 4,900,000	$ 178,182	35	$ 140,000	$ (38,182)	$ 420,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Installed New Lightbox Sign			2014	9,480		20	632	632	2,265	9
10	Installed New Radiator			2014	4,013		20	103	103	356	10
11	Installed New Gaf Top Roofing System,Scuppers & Front Gutters			2014	167,750	153,594	20	4,301	(149,293)	14,875	11
12	Installed 6 Strand Multimode Fiber Optic Cable Between Mdf & Idf			2014	19,691		20	505	505	1,915	12
13	Ashphalt Back & Front Lot, Replace Concrete Ramps With Aspha			2014	52,010		20	1,334	1,334	4,279	13
14	Insulation In The Entire Attic			2014	3,032		20	78	78	243	14
15	Marble Flooring In Bathrooms			2014	5,119		20	131	131	399	15
16	Install New Sprinkler Heads In All Bathrooms 100-115			2015	13,926		20	696	696	1,915	16
17	A/C Hva And Freon			2015	2,907		20	145	145	375	17
18	Sprinkler Pipe Work			2015	2,554		20	128	128	330	18
19	Installed Flooring			2015	16,641		20	832	832	1,941	19
20	Installed Tek-Call Visual Nurses Call Signaling System In Wing			2015	13,356		20	668	668	1,503	20
21	Electrical Trimming In 5 Rooms			2015	5,861		20	293	293	659	21
22	Electrical Lighting In Hallways, Lobby & Dining Room			2015	6,660		20	333	333	749	22
23	Data Cable Installation - Ceiling , 2 New Switches, Patch Cords			2016	16,284		20	426	426	852	23
24	Paint Lobby Doors, Don Office Bathroom			2016	10,280		20	1,713	1,713	3,426	24
25	Installation - Window Treatments			2016	2,844		20	474	474	948	25
26	Straight Edge Painting / Lighting			2016	20,899		20	398	398	796	26
27	Ceramic Flooring			2016	4,455		20	64	64	128	27
28	Kitchen Remodel - Sink Faucet, Drains, Fixtures, Flooring			2016	27,186		20	259	259	518	28
29	Roofing/Parking Lot work, Wall Work Wing1, Dining Room,			2016	731,324		20	20,895	20,895	41,790	29
30	Activity Room, Conference Rooms, Wall Coverings, Fire Sprinklers										30
31	Vinyl Tile-Dining Rooms, Wallpaper, Window Treatments			2016	126,183		20	22,754	22,754	45,508	31
32	15 Rsdn Rms,Handrails -5 Corridors, Curtains(12) Rehab Rooms										32
33	Camera Installation			2016	12,223		20	2,445	2,445	4,890	33
34	Install New Gas Pipe			2016	3,899		20	28	28	56	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,178,577	$ 331,776		$ 199,635	$ (132,141)	$ 550,716	70

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,178,577	$ 331,776		$ 199,635	$ (132,141)	$ 550,716	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)		$ 6,178,577	$ 331,776		$ 199,635	$ (132,141)	$ 550,716	34

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHA# 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 531,766	$	$ 89,903	$ 89,903	5-10 YRS	$ 203,299	71
72	Current Year Purchases	27,995		1,400	1,400	10 YRS	1,400	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		48,000	25,000	(23,000)			74
75	TOTALS	$ 559,761	$ 48,000	$ 116,303	$ 68,303		$ 204,699	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)	$ 6,988,338	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 379,776	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,938	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (63,838)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 755,415	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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				562,498			4
5								5
6								6
7	TOTAL				$ 562,498 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 49,454 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN / BUS		$ 663.00	$ 7,956	17
18				43,008	18
19					19
20					20
21	TOTAL		$ 663.00	$ 50,964	21

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 331,831	$		$ 331,831	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			102,028			102,028	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			366,002			366,002	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				275,878		275,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2				33,535			33,535	13
14	TOTAL			$		$ 833,396	$ 275,878		$ 1,109,274	14

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

STATE OF ILLINOIS

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB **#** 0052563 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 109,519	$ 851,087	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,670))	1,967,701	1,967,701	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,177	101,177	6
7	Other Prepaid Expenses	644	50,972	7
8	Accounts Receivable (owners or related parties)	77,919	696,435	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,256,960	$ 3,667,372	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		250,000	13
14	Buildings, at Historical Cost		4,900,000	14
15	Leasehold Improvements, at Historical Cost	1,319,692	1,319,692	15
16	Equipment, at Historical Cost	647,746	897,746	16
17	Accumulated Depreciation (book methods)	(794,763)	(1,413,142)	17
18	Deferred Charges		64,728	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,510,337	21
22	Other Long-Term Assets (spe**alf project**		80,176	22
23	Other(specify): goodwill		544,546	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,172,675	$ 8,154,083	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,429,635	$ 11,821,455	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,315,882	$ 1,315,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,754	1,754	28
29	Short-Term Notes Payable	875,000	875,000	29
30	Accrued Salaries Payable	177,950	177,950	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		102,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Related Party	202,516	202,516	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,573,102	$ 2,675,102	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,500,000	39
40	Mortgage Payable		7,400,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,900,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,573,102	$ 11,575,102	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 856,533	$ 246,353	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,429,635	$ 11,821,455	48

***(See instructions.)**

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 493,578	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 493,578	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	362,955	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)**	$ 362,955	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)**	$ 856,533	24 *

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

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REH # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,605,323	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,605,323	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,272	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 139,272	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	1,153	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)**	$ 1,153	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,631	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,631	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	2,747	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,747	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,750,126	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,034,729	31
32	Health Care	2,273,170	32
33	General Administration	1,838,869	33
	B. Capital Expense		
34	Ownership	881,114	34
	C. Ancillary Expense		
35	Special Cost Centers	1,109,274	35
36	Provider Participation Fee	250,015	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,387,171	40
41	**Income before Income Taxes (line 30 minus line 40)****	362,955	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 362,955	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,040,655	44
45	Private Pay - Net Inpatient Revenue	554,376	45
46	Medicare - Net Inpatient Revenue	3,245,311	46
47	Other-(specify) INSURANCE	469,051	47
48	Other-(specify) HOSPICE	295,930	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,605,323	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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 NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,428	1,641	$ 69,692	$ 42.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,288	17,814	521,138	29.25	3
4	Licensed Practical Nurses	14,710	15,729	379,090	24.10	4
5	CNAs & Orderlies	63,500	66,256	788,994	11.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,264	10,170	102,953	10.12	10
11	Social Service Workers	1,993	2,457	33,299	13.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,221	4,518	81,063	17.94	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,786	1,859	101,444	54.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,744	11,108	224,390	20.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,664	1,778	30,143	16.95	31
32	Other Health C: MDS	1,401	1,426	51,436	36.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,999	134,756	$ 2,383,642 *	$ 17.69	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	6,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	71,000	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 77,600		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	166	$ 12,981	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	166	$ 12,981		53

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHA] # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JENNIFER HOPPE	ADMINISTRATOR		$ 101,444
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,444

B. Administrative - Other

Description	Amount
RIVER NORTH BUILDING	$ 140,000
GREAT LAKES	120,000
DYNAMIC	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 320,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
		248,183
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 248,183

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,237
Unemployment Compensation Insurance	29,162
FICA Taxes	180,713
Employee Health Insurance	129,512
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	12,550
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,174

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,020
Health Care Worker Background Check	1,468
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	6,135
MARKETING/ADV/PROMO	20,290
LICENSES/DUES/SUBSCRIPTIONS	17,431
MGMT CO ALLOC	149
TRUST/FRANCHISE/CONTRIB/ETC	(6,135)
Less: Public Relations Expense	(0)
Non-allowable advertising	(20,290)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,068

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

RIVER NORTH OF BRADLEY HEALTH & REHAB
LEGAL FEE SCHEDULE

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
09/01/2017	MUCH SHELISH	500.00	GENERAL COUNSELING
09/24/2017	MUCH SHELISH	250.00	PREPARE AND FILE ILLINOIS DOMESTIC LIMITED LIABILITY COMPANY ANNUAL REPORT
10/01/2007	MUCH SHELISH	308.00	GENERAL COUNSELING
11/01/2017	MUCH SHELISH	462.00	GENERAL COUNSELING
12/01/2017	MUCH SHELISH	77.00	GENERAL COUNSELING
02/28/2017	SIMANDL LAW GROUP	31.92	FACILITY AUDITS
10/31/2017	STONE POGRUND & KOREY	87.90	GENERAL COLLECTIONS
11/30/2017	STONE POGRUND & KOREY	472.50	GENERAL COLLECTIONS
11/30/2017	STONE POGRUND & KOREY	463.56	GENERAL COLLECTIONS
	STONE POGRUND & KOREY	463.56	
04/30/2017	GREAT LAKES HEALTHCARE GROUP	39.50	GENERAL COUNSELING
05/31/2017	GREAT LAKES HEALTHCARE GROUP	45.00	GENERAL COUNSELING
		3,200.94	

Facility Name & ID Number RIVER NORTH OF BRADLEY HEALTH & REHAB # 0052563 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. ICLTC -$11,937

(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 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line 10-2

(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 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 250,015
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. $ 0 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
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? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name:

(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