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: 0053231

Facility Name: Rock River Health Care

Address: 707 West Riverside (Number) Rockford (City) 61103 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-5752 **Fax #** (815) 282-2203

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2014

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	124	51	2,622	2,797	8
9	SNF/PED					9
10	ICF	20,447	193	1,540	22,180	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,571	244	4,162	24,977	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.64%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 69 and days of care provided 2,162

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	222,183	15,981	7,104	245,268		245,268		245,268			1
2	Food Purchase		148,859		148,859		148,859	453	149,312			2
3	Housekeeping	160,538	13,240		173,778		173,778	1,933	175,711			3
4	Laundry	48,083	11,115		59,198		59,198		59,198			4
5	Heat and Other Utilities			105,696	105,696		105,696	(4,822)	100,874			5
6	Maintenance	17,947	22,093	28,136	68,176		68,176	1,329	69,505			6
7	Other (specify):*											7
8	TOTAL General Services	448,751	211,288	140,936	800,975		800,975	(1,106)	799,869			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,301,556	22,208	160,489	1,484,253		1,484,253	(59,004)	1,425,249			10
10a	Therapy											10a
11	Activities	87,111	3,455		90,566		90,566		90,566			11
12	Social Services	145,798		2,606	148,404		148,404		148,404			12
13	CNA Training											13
14	Program Transportation			452	452		452		452			14
15	Other (specify):*							5,997	5,997			15
16	TOTAL Health Care and Programs	1,534,465	25,663	170,747	1,730,875		1,730,875	(53,007)	1,677,868			16
	C. General Administration											
17	Administrative	152,535		306,200	458,735		458,735	(207,062)	251,673			17
18	Directors Fees											18
19	Professional Services			78,091	78,091	(267)	77,824	(15,880)	61,944			19
20	Dues, Fees, Subscriptions & Promotions			35,640	35,640		35,640	(9,038)	26,602			20
21	Clerical & General Office Expenses	81,518		58,639	140,157		140,157	70,743	210,900			21
22	Employee Benefits & Payroll Taxes			337,395	337,395		337,395		337,395			22
23	Inservice Training & Education											23
24	Travel and Seminar							1,221	1,221			24
25	Other Admin. Staff Transportation			9,989	9,989		9,989	3,454	13,443			25
26	Insurance-Prop.Liab.Malpractice			167,189	167,189		167,189	792	167,981			26
27	Other (specify):*							29,263	29,263			27
28	TOTAL General Administration	234,053		993,143	1,227,196	(267)	1,226,929	(126,506)	1,100,423			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,217,269	236,951	1,304,826	3,759,046	(267)	3,758,779	(180,619)	3,578,159			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 Rock River Health Care #0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			23,635	23,635		23,635	203,744	227,379			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,524	17,524		17,524	234,610	252,134			32
33	Real Estate Taxes			87,917	87,917	267	88,184	397	88,581			33
34	Rent-Facility & Grounds			599,056	599,056		599,056	(588,903)	10,153			34
35	Rent-Equipment & Vehicles			5,285	5,285		5,285		5,285			35
36	Other (specify):*											36
37	**TOTAL Ownership**			733,417	733,417	267	733,684	(150,152)	583,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,192	268,483	367,675		367,675		367,675			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,494	206,494		206,494		206,494			42
43	Other (specify):*			12,095	12,095		12,095	(12,095)	(0)			43
44	**TOTAL Special Cost Centers**		99,192	487,072	586,264		586,264	(12,095)	574,169			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,217,269	336,143	2,525,315	5,078,727		5,078,727	(342,867)	4,735,860			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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(6,075)	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	(78,588)	30		9
10	Interest and Other Investment Income	(7,340)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(4,970)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,268)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (183,256)		$	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)	(159,611)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (159,611)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (342,867)		37

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

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

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

Rock River Health Care

ID# 0053231

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (21,046)	21	1
2	Vending Income	(733)	02	2
3	Marketing Expense	(12,095)	43	3
4	Bank Charges	(5,887)	21	4
5	Additional R&M	235	06	5
6	PAC Dues	(8,899)	20	6
7	Bldg Co. - Professional Fees	(14,335)	19	7
8	Non-Allowable Legal	(6,501)	19	8
9	Prior Period Adjustment - Professional Fees	(11,074)	19	9
10	Medical Records Income	(818)	10	10
11	Bldg Co. - Amortization	(4,115)	36	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**	(85,268)		49

Rock River Health Care

ID# 0053231

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock River Health Care # 0053231 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(748)		1,032		169							453	2
3	Housekeeping			1,933									1,933	3
4	Laundry													4
5	Heat and Other Utilities	(6,075)		1,253									(4,822)	5
6	Maintenance	235		1,094									1,329	6
7	Other (specify):*													7
8	**TOTAL General Services**	(6,588)		5,313		169							(1,106)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(818)				32,132	(90,318)						(59,004)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,972	1,025						5,997	15
16	**TOTAL Health Care and Programs**	(818)				37,104	(89,293)						(53,007)	16
	C. General Administration													
17	Administrative			(134,049)			(73,013)						(207,062)	17
18	Directors Fees													18
19	Professional Services	(31,910)	14,335	849	68	188	590						(15,880)	19
20	Fees, Subscriptions & Promotions	(9,899)		813	17	31							(9,038)	20
21	Clerical & General Office Expenses	(31,903)		79,391		10,261	12,994						70,743	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			299		586	337						1,221	24
25	Other Admin. Staff Transportation			5		1,893	1,556						3,454	25
26	Insurance-Prop.Liab.Malpractice			490		302							792	26
27	Other (specify):*			14,918		1,145	13,200						29,263	27
28	**TOTAL General Administration**	(73,712)	14,335	(37,284)	85	14,406	(44,336)						(126,506)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,118)	14,335	(31,971)	85	51,679	(133,630)						(180,619)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rock River Health Care** **#** **0053231** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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	(78,588)	280,473	5	1,854								203,744	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,340)	240,746	0	1,203								234,610	32
33	Real Estate Taxes		(2,325)		2,722								397	33
34	Rent-Facility & Grounds		(599,056)	14,848	(4,695)								(588,903)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(4,115)	4,115											36
37	**TOTAL Ownership**	(90,043)	(76,047)	14,854	1,084								(150,152)	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):*	(12,095)											(12,095)	43
44	**TOTAL Special Cost Centers**	(12,095)											(12,095)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(183,256)	(61,712)	(17,117)	1,169	51,679	(133,630)						(342,867)	45

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Rental Income	$ 599,056	Rock River Health Care Realty LLC	100.00%	$	$ (599,056)	1
2	V	19	Professional Fees		Rock River Health Care Realty LLC	100.00%	14,335	14,335	2
3	V	32	Interest Expense		Rock River Health Care Realty LLC	100.00%	240,746	240,746	3
4	V	33	Real Estate Taxes	87,917	Rock River Health Care Realty LLC	100.00%	85,592	(2,325)	4
5	V	30	Depreciation		Rock River Health Care Realty LLC	100.00%	280,473	280,473	5
6	V	36	Amortization		Rock River Health Care Realty LLC	100.00%	4,115	4,115	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 686,973			$ 625,261	$ * (61,712)	14

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	$ 1,032	$ 1,032	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,933	1,933	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,253	1,253	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,094	1,094	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,191	10,191	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8,861	8,861	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	849	849	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	813	813	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,725	3,725	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	75,666	75,666	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	299	299	25
26	V	25	AUTO EXPENSE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	5	5	26
27	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	490	490	27
28	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,918	14,918	28
29	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	5	5	29
30	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	0	0	30
31	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,848	14,848	31
32	V								32
33	V	17	MANAGEMENT FEES	153,100	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(153,100)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 153,100			$ 135,983	$ * (17,117)	39

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	68	$ 68	15
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	17	17	16
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	1,854	1,854	17
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,203	1,203	18
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	2,722	2,722	19
20	V								20
21	V	34	RENT	4,695	PREMIER HC REAL ESTATE, LLC	100.00%		(4,695)	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			$ 4,695			$ 5,864	$ * 1,169	39

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	iCare Consulting Services LLC	100.00%	$ 169	$ 169	15
16	V	10	NURSING SALARIES	1,800	iCare Consulting Services LLC	100.00%	33,932	32,132	16
17	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	4,972	4,972	17
18	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	188	188	18
19	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	31	31	19
20	V	21	CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	1,765	1,765	20
21	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	8,496	8,496	21
22	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	586	586	22
23	V	25	AUTO EXPENSE		iCare Consulting Services LLC	100.00%	1,893	1,893	23
24	V	26	INSURANCE		iCare Consulting Services LLC	100.00%	302	302	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,145	1,145	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			$ 1,800			$ 53,479	$ * 51,679	39

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10	NURSE CONSULANT SALARIES	95,949	SABA Healthcare	100.00%	5,631	$ (90,318)	15
16	V	15	EMPLOYEE BEN. HC PROGRAMS		SABA Healthcare	100.00%	1,025	1,025	16
17	V	17	ADMIN SALARY -RELATED	48,000	SABA Healthcare	100.00%	68,203	20,203	17
18	V	17	ADMIN SALARY- NON RELATED		SABA Healthcare	100.00%	59,884	59,884	18
19	V	19	PROFESSIONAL FEES		SABA Healthcare	100.00%	590	590	19
20	V	21	CLERICAL AND GENERAL		SABA Healthcare	100.00%	370	370	20
21	V	21	CLERICAL & GENERAL SALARIES		SABA Healthcare	100.00%	12,624	12,624	21
22	V	24	SEMINARS & EDUCATION		SABA Healthcare	100.00%	337	337	22
23	V	25	AUTO EXPENSE		SABA Healthcare	100.00%	1,556	1,556	23
24	V	27	EMPLOYEE BEN. GEN ADMIN.		SABA Healthcare	100.00%	13,200	13,200	24
25	V								25
26	V	17	MANAGEMENT FEES	153,100	SABA Healthcare	100.00%		(153,100)	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			$ 297,049			$ 163,419	$ * (133,630)	39

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	17.50%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO	1
2	Yeruchom Levovitz	14.42%	PARK VIEW REHAB CENTER	CHICAGO	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO	2
3	Moshe Levovitz	1.54%	PINE CREST HEALTH CARE	HAZEL CREST	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING CO	3
4	CTCAAR LLC	1.54%	RIVER VIEW REHAB CENTER	ELGIN	SABA HEALTHCARE	SKOKIE, IL	CONSULTING CO	4
5	Kevin Chankin	2.50%	FOREST CITY REHAB & NURSING	ROCKFORD	ROCK RIVER HC REALTY	ROCKFORD, IL	BUILDING CO	5
6	Aharon Singer	13.25%	PEARL PAVILION	FREEPORT				6
7	Benzion Fishbane	1.00%						7
8	Moshe Blonder	13.25%						8
9	ATIED Associates LLC	20.00%						9
10	SMF Healthcare LLC	15.00%						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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	17.50%	See Attachment	2.72	6.80%	Alloc Salary	$ 10,191	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	14.42%	See Attachment	2.72	6.80%	Alloc Salary	8,861	17-7	2
3	Kevin Chankin	Owner	Clerical	2.50%	See Attachment	2.72	6.80%	Alloc Salary	13,605	21-7	3
4	Tzvi Singer	Relative	Administrative	0%	See Attachment	40	100.00%	Alloc Salary	76,005	17-1	4
5	Moshe Blonder	Owner	Administrative	13.25%	See Attachment	6.82	17.05%	Alloc Salary	34,102	17-7	5
6	Aharon Singer	Owner	Administrative	13.25%	See Attachment	6.82	17.05%	Alloc Salary	34,102	17-7	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	$ 176,866		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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	365,085	10	$ 15,162	$	24,842	$ 1,032	1
2	3	HOUSEKEEPING	PATIENT DAYS	365,085	10	28,415		24,842	1,933	2
3	5	UTILITIES	PATIENT DAYS	365,085	10	18,421		24,842	1,253	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	365,085	10	16,085		24,842	1,094	4
5	17	S WEBSTER SALARY	PATIENT DAYS	365,085	10	149,768	149,768	24,842	10,191	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	365,085	10	130,217	130,217	24,842	8,861	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	12,478		24,842	849	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	11,953		24,842	813	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	54,741		24,842	3,725	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	1,112,012	1,112,012	24,842	75,666	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	4,389		24,842	299	11
12	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	69		24,842	5	12
13	26	INSURANCE	PATIENT DAYS	365,085	10	7,200		24,842	490	13
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	219,241		24,842	14,918	14
15	30	DEPRECIATION	PATIENT DAYS	365,085	10	79		24,842	5	15
16	32	INTEREST	PATIENT DAYS	365,085	10	4		24,842	0	16
17	34	RENT	PATIENT DAYS	365,085	10	218,217		24,842	14,848	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,451	$ 1,391,997		$ 135,983	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	1,000		24,842	68	1
2	20	LICENSES & PERMITS	PATIENT DAYS	365,085	10	250		24,842	17	2
3	30	DEPRECIATION	PATIENT DAYS	365,085	10	27,243		24,842	1,854	3
4	32	INTEREST EXPENSE	PATIENT DAYS	365,085	10	17,683		24,842	1,203	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	365,085	10	40,000		24,842	2,722	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					$ 86,176	$		$ 5,864	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	365,085	10	$ 2,486	$	24,842	$ 169	1
2	10	NURSING SALARIES	PATIENT DAYS	365,085	10	498,679	498,679	24,842	33,932	2
3	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	365,085	10	73,073		24,842	4,972	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	2,768		24,842	188	4
5	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	459		24,842	31	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	25,935		24,842	1,765	6
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	124,859	124,859	24,842	8,496	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	8,610		24,842	586	8
9	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	27,819		24,842	1,893	9
10	26	INSURANCE	PATIENT DAYS	365,085	10	4,434		24,842	302	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	16,833		24,842	1,145	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					$ 785,955	$ 623,538		$ 53,479	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Saba Healthcare
Street Address: 8153 N. Lawndale
City / State / Zip Code: Skokie, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSE CONSULANT SALARIE	PATIENT DAYS	145,694	6	33,022	33,022	24,842	5,631	1
2	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	145,694	6	6,012		24,842	1,025	2
3	17	ADMIN SALARY -RELATED	PATIENT DAYS	145,694	6	400,000	400,000	24,842	68,203	3
4	17	ADMIN SALARY- NON RELATI	PATIENT DAYS	145,694	6	351,207	351,207	24,842	59,884	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	145,694	6	3,459		24,842	590	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	145,694	6	2,173		24,842	370	6
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	145,694	6	74,035	74,035	24,842	12,624	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	145,694	6	1,975		24,842	337	8
9	25	AUTO EXPENSE	PATIENT DAYS	145,694	6	9,126		24,842	1,556	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	145,694	6	77,416		24,842	13,200	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					$ 958,425	$ 858,264		$ 163,419	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$ 5,471,019			$ 240,746	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Note Payable				345,000			17,524	6
7	Alloc Premier HC Realty	X									1,203	7
8												8
9	TOTAL Facility Related						$	$ 5,816,019			$ 259,473	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,340)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,340)	14
15	TOTALS (line 9+line14)						$	$ 5,816,019			$ 252,133	15

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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.**	$ 80,000	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.)		$ 88,313	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,313	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,000	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.)		$ 267	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.		$ 88,581	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013	76,593	9
2014	77,140	10
2015	86,670	11
2016	85,592	12

Allocated from Premier HC Realty = $2,722

	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 Rock River Health Care COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0053231

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.	11-01-304-008	Long Term Care Property	$ 85,591.54	$ 85,591.54
2.	10-23-324-047-0000	Allocated from Premier HC Realty LI	$ 34,107.75	$ 2,320.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 119,699.29	$ 87,912.38

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock River Health Care COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0053231

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.			$	$
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 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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,200 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	250,035	2014	$ 175,000	1
2	Allocated From Premier HC Realty			1,293	2
3	TOTALS	250,035		$ 176,293	3

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	130		2014	1977	$ 3,000,000	$ 280,473	35	$ 85,714	$ (194,759)	$ 342,857	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		400,000			20,000	20,000	60,000	67
68	Related Party Allocations (Pages 12H & 12I)		76,863	1,845		3,230	1,385	19,366	68
69	Financial Statement Depreciation			23,635			(23,635)		69
70	TOTAL (lines 4 thru 69)		$ 3,476,863	$ 305,953		$ 108,944	$ (197,009)	$ 422,223	70

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 3,476,863	$ 305,953		$ 108,944	$ (197,009)	$ 422,223	1
2	Security Camera-16 Channel Nvr - Dome Camera Wall Mount	2015	7,130		20	357	357	980	2
3	Security Camera-Wiring, Jacks, Surface Boxes, Plates	2015	13,405		20	670	670	1,843	3
4	Replaced Chiller - High Pressure Control	2015	10,959		20	548	548	1,370	4
5	Replacement Of Boiler	2015	4,448		20	222	222	463	5
6	Water System Installation, Tap Water Aami Analysis	2016	5,665		20	283	283	567	6
7	Replace Leaking Tubes In Boiler, Re-Line Front Firebox Door	2016	3,800		20	190	190	348	7
8	Boiler Pump Replacement	2016	8,634		20	432	432	755	8
9	Boiler Improvements	2016	4,478		20	224	224	410	9
10	Chiller Work	2016	5,369		20	268	268	425	10
11	Set Up Temporary Carrier Chiller	2016	5,818		20	291	291	461	11
12	2 New Boilers	2016	25,560		20	1,278	1,278	1,598	12
13	Elevator Modernization	2017	29,500		20	1,229	1,229	1,229	13
14	Repair Step Leading Into Basement	2017	2,500		20	104	104	104	14
15	13 Sprinkler Heads	2017	3,728		20	140	140	140	15
16	Removed/Installed New Chiller And Cooling Tower - Kitchen	2017	83,700		20	4,185	4,185	4,185	16
17	Architecture Fees- Associated With Renovations	2017	8,500		20	425	425	425	17
18	Renovated Main/2Nd Fl Vestibule,Resident Rooms,Dining Room,(	2017	944,072		20	47,204	47,204	47,204	18
19	Boiler Room & West Wing Asbestos Survey, Inspection & Abatem	2017	40,745		20	2,037	2,037	2,037	19
20	Title Fees	2017	2,500		20	125	125	125	20
21	Pumps And Boilers	2017	48,780		20	2,439	2,439	2,439	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)		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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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)		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 4,736,154	$ 305,953		$ 171,596	$ (134,357)	$ 489,332	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Asphalt-Garbage Pad & Sidewalks(Front Prmter),Glass & Doors i	2015	400,000		20	20,000	20,000	60,000	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)		$ 400,000	$		$ 20,000	$ 20,000	$ 60,000	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 400,000	$		$ 20,000	$	$ 60,000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 400,000	$		$ 20,000	$	$ 60,000	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Premier Healthcare Realty	2011	25,340	650	39	724	74	4,404	3
4	Premier Healthcare Realty	2012	3,226	83	39	92	9	553	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Premier HealthCare & Financial Services, Inc	2012	45,069	1,074	20	2,253	1,179	13,709	9
10	Premier HealthCare & Financial Services, Inc	2016	1,306	33	20	65	32	392	10
11									11
12	Allocated from Premier Healthcare Realty	2011	575	5	20	29	24	173	12
13	Allocated from Premier Healthcare Realty	2012	1,347		20	67	67	135	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)		$ 76,863	$ 1,845		$ 3,230	$ 1,385	$ 19,366	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 76,863	$ 1,845		$ 3,230	$ 1,385	$ 19,366	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,863	$ 1,845		$ 3,230	$ 1,385	$ 19,366	34

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 409,169	$ 14	$ 46,144	$ 46,130	10	$ 174,142	71
72	Current Year Purchases	96,391		9,639	9,639	10	9,639	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 505,560	$ 14	$ 55,783	$ 55,769		$ 183,781	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)	$ 5,418,007	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 305,967	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 227,379	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (78,588)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 673,113	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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Premier				10,153			6
7	TOTAL				$ 10,153 **			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: $ 5,285 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 130,423	$		$ 130,423	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			26,617			26,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			109,131			109,131	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				37,580		37,580	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					2,312	61,612		63,924	13
14	TOTAL			$		$ 268,483	$ 99,192		$ 367,675	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 Rock River Health Care **#** 0053231 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 19,221	$ 71,851	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,163,531	1,163,531	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,935	159,935	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	28,083	70,879	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,370,770	$ 1,466,196	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		175,000	13
14	Buildings, at Historical Cost		2,267,059	14
15	Leasehold Improvements, at Historical Cost	58,676	1,646,633	15
16	Equipment, at Historical Cost	85,036	1,123,734	16
17	Accumulated Depreciation (book methods)	(56,806)	(1,194,583)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		81,784	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(13,103)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	118	1,031,968	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 87,024	$ 5,118,492	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,457,794	$ 6,584,688	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 377,798	$ 377,799	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,804	174,804	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,825	6,825	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	28,048	538,318	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 587,475	$ 1,177,746	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	345,000	345,000	39
40	Mortgage Payable		5,471,019	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	325,000	325,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 670,000	$ 6,141,019	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,257,475	$ 7,318,765	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 200,319	$ (734,077)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,457,794	$ 6,584,688	48

***(See instructions.)**

Facility Name & ID Number Rock River Health Care **#** 0053231 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 690,848	1
2	Restatements (describe):		2
3	Equity Adjustment	(267,498)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 423,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(223,031)	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)**	$ (223,031)	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)**	$ 200,319	24 *

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 4,713,063	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,713,063	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,340	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,340	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	135,293	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135,293	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,855,696	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	800,975	31
32	Health Care	1,730,875	32
33	General Administration	1,227,196	33
	B. Capital Expense		
34	Ownership	733,417	34
	C. Ancillary Expense		
35	Special Cost Centers	379,770	35
36	Provider Participation Fee	206,494	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,078,727	40
41	**Income before Income Taxes (line 30 minus line 40)****	(223,031)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (223,031)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,268,321	44
45	Private Pay - Net Inpatient Revenue	73,211	45
46	Medicare - Net Inpatient Revenue	940,602	46
47	Other-(specify) Hospice	291,763	47
48	Other-(specify) Commercial	139,166	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,713,063	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 Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,894	1,911	$ 72,927	$ 38.16	1
2	Assistant Director of Nursing	976	1,072	31,258	29.16	2
3	Registered Nurses	8,215	8,659	266,992	30.83	3
4	Licensed Practical Nurses	13,582	14,337	369,883	25.80	4
5	CNAs & Orderlies	39,494	41,811	536,011	12.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,072	29,740	14.35	9
10	Activity Assistants	4,160	4,610	57,371	12.44	10
11	Social Service Workers	5,168	5,417	145,798	26.91	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,080	57,586	27.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,068	14,433	164,597	11.40	15
16	Dishwashers					16
17	Maintenance Workers	1,770	1,869	17,947	9.60	17
18	Housekeepers	12,000	13,220	160,538	12.14	18
19	Laundry	4,973	5,243	48,083	9.17	19
20	Administrator	4,078	4,193	152,535	36.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,198	6,651	81,518	12.26	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	1,365	1,498	24,485	16.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,829	129,076	$ 2,217,269 *	$ 17.18	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	132	$ 7,104	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	97,749	10-03	38
39	Pharmacist Consultant	Monthly	4,180	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				44
45	Social Service Consultant	40	2,606	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	1,172	58,560	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,344	$ 177,399		49

C. CONTRACT NURSES

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steve Bennett	Administrator	0	$ 76,530
Tzvi Singer	Administrator	0	76,005
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,535

B. Administrative - Other

Description	Amount
Management Fees - Premier HC & Financial Services	$ 153,100
Management Fees - Saba Healthcare	153,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 306,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 9,201
Marcum LLP	Accounting Fees	15,863
MTS Consulting	Tax Consulting	2,746
Mowery & Schoenfeld	Accounting Fees	1,643
Prospect Resources	Energy Procurement	600
Kevin Chankin	Other Professional Fees	126
Balahadia & Gates PLLC	Immigration Attorney	2,200
Creative Technology	Computer Services	8,952
Reliable Health Systems	Computer Services	12,120
Zirmed	Computer Services	636
Experian	Computer Services	172
See Supplemental Schedule		23,832
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 78,091

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,942
Unemployment Compensation Insurance	70,006
FICA Taxes	161,485
Employee Health Insurance	30,850
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	9,028
Holiday Expense	1,085
TOTAL (agree to Schedule V, line 22, col.8)	$ 337,396

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	2,784
Health Care Worker Background Check	5,598
(Indicate # of checks performed 560)	
Patient Background Checks	
Dues & Subsrciptions	8,898
Licenses & Permits	4,481
Allocated from iCare Consulting	31
Allocated from Premier HC & Financial	813
See Supplemental Schedule	17
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,602

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Premier HC & Financial	299
Allocated from iCare Consulting	586
See Supplemental Schedule	337
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,222

**See instructions.

Facility Name & ID Number Rock River Health Care # 0053231 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $17,797**

(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. $ **14,475** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **206,494**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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