

		FOR BHF USE					

LL1

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

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

<p>I. IDPH License ID Number: <u>0053322</u></p> <p>Facility Name: <u>Rock River Gardens</u></p> <p>Address: <u>3601 Sixteenth Avenue</u> <u>Sterling</u> <u>61081</u> Number City Zip Code</p> <p>County: <u>Whiteside</u></p> <p>Telephone Number: <u>(815)626-0233</u> Fax # <u>(815)626-6740</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/1/2014</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																			
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																			
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																			
	<input type="checkbox"/> "Sub-S" Corp.																																				
	<input checked="" type="checkbox"/> Limited Liability Co.																																				
	<input type="checkbox"/> Trust																																				
	<input type="checkbox"/> Other _____																																				
Officer or Administrator of Provider	(Signed) _____																																				
	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____																																				
	(Title) <u>Chief Executive Officer</u>																																				
Paid Preparer	(Signed) _____																																				
	(Date) _____																																				
	(Print Name and Title) _____																																				
	(Firm Name & Address) _____																																				
	(Telephone) <u>()</u> Fax # <u>()</u>																																				

Facility Name & ID Number Rock River Gardens

0053322 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	20,597	72		20,669	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,597	72		20,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.90%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/2014 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	153,669	12,969	593	167,231		167,231	5,020	172,251		1
2	Food Purchase		138,231		138,231		138,231	(2,722)	135,509		2
3	Housekeeping	112,880	13,624		126,504		126,504	80	126,584		3
4	Laundry		6,696		6,696		6,696		6,696		4
5	Heat and Other Utilities			39,417	39,417		39,417	257	39,674		5
6	Maintenance	47,247	3,623	16,465	67,335		67,335	1,969	69,304		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	313,796	175,143	56,475	545,414		545,414	4,604	550,018		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	809,867	26,166	25,103	861,136		861,136	3,363	864,499		10
10a	Therapy										10a
11	Activities	65,651			65,651		65,651	(1,454)	64,197		11
12	Social Services	78,238			78,238		78,238		78,238		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	953,756	26,166	43,103	1,023,025		1,023,025	1,909	1,024,934		16
	C. General Administration										
17	Administrative			190,000	190,000		190,000	(120,367)	69,633		17
18	Directors Fees										18
19	Professional Services			1,258	1,258		1,258	31,163	32,421		19
20	Dues, Fees, Subscriptions & Promotions			2,730	2,730		2,730	3,724	6,454		20
21	Clerical & General Office Expenses	36,784	2,243	9,797	48,824		48,824	51,480	100,304		21
22	Employee Benefits & Payroll Taxes			132,637	132,637		132,637	21,633	154,270		22
23	Inservice Training & Education							126	126		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			2,929	2,929		2,929	3,821	6,750		25
26	Insurance-Prop.Liab.Malpractice			25,430	25,430		25,430	958	26,388		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	36,784	2,243	364,781	403,808		403,808	(7,459)	396,349		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,304,336	203,552	464,359	1,972,247		1,972,247	(946)	1,971,301		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 Gardens

#0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,723	3,723		3,723	14,062	17,785			30
31	Amortization of Pre-Op. & Org.							110	110			31
32	Interest							3,155	3,155			32
33	Real Estate Taxes			9,954	9,954		9,954	379	10,333			33
34	Rent-Facility & Grounds			70,000	70,000		70,000		70,000			34
35	Rent-Equipment & Vehicles			6,288	6,288		6,288	1,727	8,015			35
36	Other (specify):*											36
37	TOTAL Ownership			89,965	89,965		89,965	19,433	109,398			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			163,695	163,695		163,695		163,695			42
43	Other (specify):* Miscellaneous		394	47,154	47,548		47,548	(47,548)				43
44	TOTAL Special Cost Centers		394	210,849	211,243		211,243	(47,548)	163,695			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,304,336	203,946	765,173	2,273,455		2,273,455	(29,061)	2,244,394			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 Gardens

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,769)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,224)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(49)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(220)	43		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	(26,795)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(277)	43		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	(1,626)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,960)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	22,899	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,899		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (29,061)		37

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

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

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

Rock River Gardens

ID# 0053322

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Offset Miscellaneous Office Supplies Revenue	\$ (29)	21	1
2	Disallowed Special Events	(32)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	\$ (111)	10	3
4	Offset Transportation Revenue	(1,454)	11	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,626)		49

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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,020	\$ 5,020	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	47	47	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	80	80	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	257	257	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,969	1,969	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,474	3,474	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	100,000	Petersen Health Care Management, Inc.	100.00%	69,633	(30,367)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	15,194	15,194	12
13	V							13
14	Total		\$ 100,000			\$ 95,674	\$ * (4,326)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,724	\$	3,724	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	51,509		51,509	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	21,633		21,633	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	126		126	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	3		3	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,821		3,821	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	958		958	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	12,182		12,182	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	110		110	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	3,204		3,204	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	379		379	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,104		1,104	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		\$			\$ 98,753	\$ *	98,753	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	
24	V	17 Administrative	90,000	Midwest Health Operations, LLC	100.00%	0	(90,000)
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	15,969	15,969
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0	
33	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	1,880	1,880
34	V	31 Amortization		Midwest Health Operations, LLC	100.00%	0	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	623	623
39	Total		\$ 90,000			\$ 18,472	\$ * (71,528)

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

Facility Name & ID Number

Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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 Gardens # 0053322 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	20,669	\$ 5,020	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	20,669	47	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	20,669	80	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	20,669	257	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	20,669	1,969	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	20,669	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	20,669	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	20,669	3,474	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	20,669	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	20,669	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	20,669	69,633	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	20,669	15,194	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	20,669	3,724	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	20,669	51,509	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	20,669	21,633	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	20,669	126	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	20,669	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	20,669	3,821	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	20,669	958	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	20,669	12,182	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	20,669	110	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	20,669	3,204	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	20,669	379	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	20,669	1,104	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 194,427	25

Facility Name & ID Number Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Midwest Health Operations, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309)691-8113
 Fax Number (309)691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	84,622	6	\$	\$	20,669	\$	1
2	2	Food	Resident Days	84,622	6			20,669		2
3	3	Housekeeping	Resident Days	84,622	6			20,669		3
4	4	Laundry	Resident Days	84,622	6			20,669		4
5	5	Utilities	Resident Days	84,622	6			20,669		5
6	6	Maintenance	Resident Days	84,622	6			20,669		6
7	7	Mgmt. Allocation of Benefits	Resident Days	84,622	6			20,669		7
8	10	Nursing and Medical Records	Resident Days	84,622	6			20,669		8
9	15	Mgmt. Allocation of Benefits	Resident Days	84,622	6			20,669		9
10	17	Administrative	Resident Days	84,622	6			20,669		10
11	19	Professional Services	Resident Days	84,622	6	65,378		20,669	15,969	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	84,622	6			20,669		12
13	21	Clerical and General Office	Resident Days	84,622	6			20,669		13
14	22	Employee Benefits & Payroll	Resident Days	84,622	6			20,669		14
15	23	Inservice Training & Education	Resident Days	84,622	6			20,669		15
16	24	Travel and Seminar	Resident Days	84,622	6			20,669		16
17	25	Other Admin. Staff Transport.	Resident Days	84,622	6			20,669		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	84,622	6			20,669		18
19	30	Depreciation	Resident Days	84,622	6	7,696		20,669	1,880	19
20	31	Amortization	Resident Days	84,622	6			20,669		20
21	32	Interest	Resident Days	84,622	6			20,669		21
22	33	Real Estate Taxes	Resident Days	84,622	6			20,669		22
23	34	Rent-Facility and Grounds	Resident Days	84,622	6			20,669		23
24	35	Rent-Equipment & Vehicles	Resident Days	84,622	6	2,549		20,669	623	24
25	TOTALS					\$ 75,623	\$		\$ 18,472	25

Facility Name & ID Number

Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1			X					\$				\$						
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related							\$	\$			\$						
B. Non-Facility Related*																		
10									Interest Income Offset			(49)						
11									Home Office Allocation-PHCM			3,204						
12																		
13																		
14	TOTAL Non-Facility Related							\$	\$			\$ 3,155						
15	TOTALS (line 9+line14)							\$	\$			\$ 3,155						

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.		\$	10,428	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.)		\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(10,428)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	20,382	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			379	
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.		\$	10,333	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013		8
	2014	10,073	9
	2015	10,236	10
	2016	10,123	11
	2017	10,038	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock River Gardens COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0053322

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-10-329-006</u>	<u>Long-Term Care Facility</u>	\$ <u>10,037.82</u>	\$ <u>10,037.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>10,037.82</u></u>	\$ <u><u>10,037.82</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Rock River Gardens

0053322 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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

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

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

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

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

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

N/A

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

If so, please complete the following:

1. Total Amount Incurred: 41,771 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 110 4. Dates Incurred: 2016

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	<u>Land</u>	<u>217,800</u>		\$	<u>1</u>
2					<u>2</u>
3	TOTALS	217,800		\$	3

Facility Name & ID Number **Rock River Gardens**

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Water Heater		2015	6,645		7	950	950	3,325	9
10	Sprinkler Repair		2016	8,815		7	1,260	1,260	3,150	10
11	Smoke Detector Repair		2017	5,004		7	714	714	1,071	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	Building Improvement Booked				2,923			(2,923)		32
33										33
34	2018-Home Office Allocation-Building Improvements			9,722			233	233		34
35	2018-Home Office Allocation-Land Improvements			975			61	61		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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 31,161		\$ 3,218	\$ 295	\$ 7,546	70

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

Facility Name & ID Number Rock River Gardens

0053322

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$	5-10 yrs.	\$	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			13,767	13,767			74
75	TOTALS	\$	\$	\$ 13,767	\$ 13,767		\$	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	Facility	2012 Ford E150 Van	2017	4,000	\$ 800	\$ 800	\$	5 yrs.	\$ 1,200	76
77										77
78										78
79										79
80	TOTALS			\$ 4,000	\$ 800	\$ 800	\$		\$ 1,200	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)	\$ 35,161	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,723	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,785	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,062	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,746	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: H & I Properties

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:	<u>1958</u>	<u>70</u>	<u>9/1/2015</u>	\$ <u>70,000</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		70		\$ 70,000			7

10. Effective dates of current rental agreement:

Beginning 9/1/2015

Ending 8/31/2020

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2019</u>	\$ <u>165,160</u>
13.	<u>12/31/2020</u>	\$ <u>165,160</u>
14.	<u>12/31/2021</u>	\$ <u>165,160</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,015 Description: See Attached Schedule 14A

(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.

Rock River Gardens

0053322

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	2,692
Dishwasher		760
Copier		2,836
Home Office Allocation		<u>1,727</u>
		<u><u>8,015</u></u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number **Rock River Gardens**

0053322

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 362,098	\$ 362,098	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>63,877</u>)	714,503	714,503	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,153	14,153	6
7	Other Prepaid Expenses	3,950	3,950	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposits</u>	6,737	6,737	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,101,441	\$ 1,101,441	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		9,722	14
15	Leasehold Improvements, at Historical Cost	20,464	21,439	15
16	Equipment, at Historical Cost	4,000	4,000	16
17	Accumulated Depreciation (book methods)	(9,797)	(8,746)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,667	\$ 26,415	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,116,108	\$ 1,127,856	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 291,444	\$ 291,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,962	42,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,075	18,075	31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,382	20,382	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	393,650	393,650	36
37	<u>Accrued Management Fees</u>	842,867	842,867	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,609,380	\$ 1,609,380	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,609,380	\$ 1,609,380	46
47	TOTAL EQUITY(page 18, line 24)	\$ (493,272)	\$ (481,524)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,116,108	\$ 1,127,856	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (217,209)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (217,210)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(276,062)	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)	\$ (276,062)	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)	\$ (493,272)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,991,712	1
2	Discounts and Allowances for all Levels	(3,370)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,988,342	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,411	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,411	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,769	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	283	21
22	Laundry	945	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,997	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,454	28
28a	<u>Miscellaneous Revenue</u>	140	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,997,393	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	545,414	31
32	Health Care	1,023,025	32
33	General Administration	403,808	33
B. Capital Expense			
34	Ownership	89,965	34
C. Ancillary Expense			
35	Special Cost Centers	47,548	35
36	Provider Participation Fee	163,695	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,273,455	40
41	Income before Income Taxes (line 30 minus line 40)**	(276,062)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (276,062)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,003,125	44
45	Private Pay - Net Inpatient Revenue	2,210	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,005,335	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Gardens

0053322

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,047	2,175	\$ 60,953	\$ 28.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,303	8,694	243,325	27.99	3
4	Licensed Practical Nurses	3,574	3,714	97,099	26.14	4
5	CNAs & Orderlies	23,197	23,955	323,684	13.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	26,833	12.90	9
10	Activity Assistants	3,058	3,156	32,192	10.20	10
11	Social Service Workers	4,160	4,160	78,238	18.81	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,321	15.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,935	13,329	122,348	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,130	3,178	47,247	14.87	17
18	Housekeepers	10,792	11,252	112,880	10.03	18
19	Laundry					19
20	Administrator	2,080	2,168	69,633	32.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,981	3,267	36,784	11.26	23
24	Clerical					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	2,080	2,080	36,326	17.46	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	3,041	3,041	55,106	18.12	33
34	TOTAL (lines 1 - 33)	85,538	88,329	\$ 1,373,969 *	\$ 15.56	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 593	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,957	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	203	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 22,753		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	198	\$ 7,041	L10, C3	50
51	Licensed Practical Nurses	434	13,268	L10, C3	51
52	Certified Nurse Assistants/Aides	38	634	L10, C3	52
53	TOTAL (lines 50 - 52)	669	\$ 20,943		53

Rock River Gardens
0053322

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	717	717	25,512	35.58
Transportation	648	648	6,626	10.23
Psychological Director	8	8	481	60.13
Psychological Assistant	1,668	1,668	22,487	13.48
TOTAL	3,041	3,041	55,106	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Angela Mehlbrech	Administrator	0	\$ 28,841	Workers' Compensation Insurance	\$ 18,502	IDPH License Fee	\$ 1,990		
Lindsay Huizenga	Administrator	0	40,792	Unemployment Compensation Insurance	17,000	Advertising: Employee Recruitment			
				FICA Taxes	94,748	Health Care Worker Background Check (Indicate # of checks performed <u>22</u>)	276		
				Employee Health Insurance	1,867	Patient Background Checks			
				Employee Meals		Miscellaneous Licenses & Permits	464		
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	3,724		
				Employee Relations	520				
				Home Office Allocation	21,633				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,633	TOTAL (agree to Schedule V, line 22, col.8)		\$ 154,270	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 190,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 190,000				Seminar Expense		
C. Professional Services				TOTAL			\$	Home Office Allocation	3
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Comcast Cable	Computer Services		\$ 1,258				TOTAL (agree to Sch. V, line 24, col. 8)		
							\$	3	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,258						

* Attach copy of IMRF notifications

**See instructions.

Rock River Gardens

0053322

Period Beginning

1/1/2018

Period End

12/31/2018

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		1,258

Home Office Allocation

Duane Morris	Legal	2077
Sedgwick CMS	Legal	184
SB2	Legal	513
Miscellaneous	Legal	153
Christopher P. Ryan	Legal	162
Saul Ewing Arnstein & Lehr	Legal	727
Healthcare Resources International	Legal	109
Winston & Strawn	Legal	1750
Lexis Nexis	Legal	7
Pretzel & Stouffer	Legal	26
Winston & Strawn	Legal	8549
CliftonLarsonAllen	Accounting	1062
Ginoli & Co.	Accounting	377
Duane Morris	Accounting	62
Getzler Henrich & Associates	Accounting	816
Kemper Consulting	Accounting	62
Baker Tilly Virchow Krause	Accounting	430
Ginoli & Co.	Accounting	2887
Miscellaneous	Computer Services	111
Change Healthcare	Computer Services	4
TR Professional	Computer Services	11
Matrix Care	Computer Services	1193
Ability Network	Computer Services	1889
Stratus Networks	Computer Services	462
Kemper Technology	Computer Services	530
AT&T	Computer Services	6
Ungerboeck Software	Computer Services	382
CIAN	Computer Services	166
Comcast	Computer Services	41
CCH	Computer Services	16
Charter Communications	Computer Services	28
Allscripts	Computer Services	537
ATS	Computer Services	249
Citrix Systems	Computer Services	87
Optimizer	Other Prof Fees	48
Sedgwick CLMS	Other Prof Fees	168
David Budde	Other Prof Fees	48
Sargent Consulting	Other Prof Fees	132
Alix Partners	Other Prof Fees	501
Getzler Henrich & Associates	Other Prof Fees	68
Alix Partners	Other Prof Fees	<u>4,533</u>

Total (agree to Schedule V, line 19, column 8)		<u>32,421</u>
--	--	---------------

Rock River Gardens

0053322

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	2,532
Auto Repairs		397
Home Office Allocation		<u>3,821</u>
		<u><u>6,750</u></u>

Facility Name & ID Number Rock River Gardens# 0053322Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 120 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 163,695
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,769
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,454
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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. \$
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (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. No
Attach invoices and a summary of services for all architect and appraisal fees