FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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: Joshua S. Banach **Telephone Number:** (773) 945-9528
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Aaron Singer
(Title) Manager

Paid Preparer

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	111	89	2,432	2,632	8
9	SNF/PED					9
10	ICF	18,240	336	2,032	20,608	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,351	425	4,464	23,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.98%

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 1,825

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	216,269	19,221	6,768	242,258		242,258		242,258			1
2	Food Purchase		136,531		136,531		136,531	233	136,764			2
3	Housekeeping	130,140	14,071		144,211		144,211	1,554	145,765			3
4	Laundry	28,294	8,539		36,833		36,833		36,833			4
5	Heat and Other Utilities			98,959	98,959		98,959	(5,204)	93,755			5
6	Maintenance	29,412		39,970	69,382		69,382	1,458	70,840			6
7	Other (specify):*											7
8	**TOTAL General Services**	404,115	178,362	145,697	728,174		728,174	(1,959)	726,215			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,314,829	28,586	167,785	1,511,200		1,511,200	(91,329)	1,419,871			10
10a	Therapy											10a
11	Activities	64,218	3,821		68,039		68,039		68,039			11
12	Social Services	99,086		2,259	101,345		101,345		101,345			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,041	1,041			15
16	**TOTAL Health Care and Programs**	1,478,133	32,407	177,244	1,687,784		1,687,784	(90,288)	1,597,496			16
	C. General Administration											
17	Administrative	76,514		237,000	313,514		313,514	(134,569)	178,945			17
18	Directors Fees											18
19	Professional Services			91,581	91,581		91,581	(4,447)	87,134			19
20	Dues, Fees, Subscriptions & Promotions			31,632	31,632		31,632	(11,365)	20,267			20
21	Clerical & General Office Expenses	90,144		88,595	178,739		178,739	5,541	184,280			21
22	Employee Benefits & Payroll Taxes			288,969	288,969		288,969		288,969			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,912	1,912		1,912	2,669	4,581			24
25	Other Admin. Staff Transportation			383	383		383	1,070	1,453			25
26	Insurance-Prop.Liab.Malpractice			178,134	178,134		178,134	292	178,426			26
27	Other (specify):*							22,796	22,796			27
28	**TOTAL General Administration**	166,658		918,206	1,084,864		1,084,864	(118,013)	966,851			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,048,906	210,769	1,241,147	3,500,822		3,500,822	(210,260)	3,290,562			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: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							226,021	226,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,215	20,215		20,215	256,131	276,346			32
33	Real Estate Taxes			85,665	85,665		85,665	2,175	87,840			33
34	Rent-Facility & Grounds			634,644	634,644		634,644	(626,217)	8,427			34
35	Rent-Equipment & Vehicles			5,131	5,131		5,131		5,131			35
36	Other (specify):*											36
37	**TOTAL Ownership**			745,655	745,655		745,655	(141,890)	603,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,725	238,972	329,697		329,697		329,697			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			203,895	203,895		203,895		203,895			42
43	Other (specify):*			2,399	2,399		2,399	(2,399)				43
44	**TOTAL Special Cost Centers**		90,725	445,266	535,991		535,991	(2,399)	533,592			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,048,906	301,494	2,432,068	4,782,468		4,782,468	(354,549)	4,427,919			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: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,191)	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	226,021	30		9
10	Interest and Other Investment Income	(2,665)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	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	(978)	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	(37,604)	21		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	(50,177)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 127,381		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 127,381		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (13,672)	21	1
2	Vending Income	(530)	02	2
3	Marketing	(2,399)	43	3
4	Bank Charges	(10,815)	21	4
5	Miscellaneous Income	(1,445)	21	5
6	PAC Dues	(10,524)	20	6
7	Building Co- Professional Fees	(5,427)	19	7
8	Non-Allowable Legal	(5,305)	19	8
9	Medical Records Income	(60)	10	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**	(50,177)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(555)	0	788	0	0	0	0	0	0	0	0	233	2
3	Housekeeping	0	0	1,554	0	0	0	0	0	0	0	0	1,554	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,191)	0	987	0	0	0	0	0	0	0	0	(5,204)	5
6	Maintenance	0	0	1,458	0	0	0	0	0	0	0	0	1,458	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,746)	0	4,787	0	0	0	0	0	0	0	0	(1,959)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(60)	0	0	0	(91,269)	0	0	0	0	0	0	(91,329)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	1,041	0	0	0	0	0	0	1,041	15
16	**TOTAL Health Care and Programs**	(60)	0	0	0	(90,228)	0	0	0	0	0	0	(90,288)	16
	C. General Administration													
17	Administrative	0	0	(85,881)	0	(48,688)	0	0	0	0	0	0	(134,569)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,732)	5,427	607	54	197	0	0	0	0	0	0	(4,447)	19
20	Fees, Subscriptions & Promotions	(11,524)	0	155	4	0	0	0	0	0	0	0	(11,365)	20
21	Clerical & General Office Expenses	(64,514)	0	55,042	0	15,013	0	0	0	0	0	0	5,541	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	345	0	2,324	0	0	0	0	0	0	2,669	24
25	Other Admin. Staff Transportation	0	0	0	0	1,070	0	0	0	0	0	0	1,070	25
26	Insurance-Prop.Liab.Malpractice	0	0	292	0	0	0	0	0	0	0	0	292	26
27	Other (specify):*	0	0	13,277	0	9,519	0	0	0	0	0	0	22,796	27
28	**TOTAL General Administration**	(86,770)	5,427	(16,163)	58	(20,565)	0	0	0	0	0	0	(118,013)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(93,576)	5,427	(11,376)	58	(110,793)	0	0	0	0	0	0	(210,260)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock River Health Care # 0053231 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	226,021	0	0	0	0	0	0	0	0	0	0	226,021	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,665)	257,815	0	981	0	0	0	0	0	0	0	256,131	32
33	Real Estate Taxes	0	0	0	2,175	0	0	0	0	0	0	0	2,175	33
34	Rent-Facility & Grounds	0	(634,644)	12,341	(3,914)	0	0	0	0	0	0	0	(626,217)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	223,356	(376,829)	12,341	(758)	0	0	0	0	0	0	0	(141,890)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,399)	0	0	0	0	0	0	0	0	0	0	(2,399)	43
44	**TOTAL Special Cost Centers**	(2,399)	0	0	0	0	0	0	0	0	0	0	(2,399)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	127,381	(371,402)	965	(700)	(110,793)	0	0	0	0	0	0	(354,549)	45

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 634,644	Rock River Health Care Realty LLC	100.00%	$	$ (634,644)	1
2	V	19	Professional Fees		Rock River Health Care Realty LLC	100.00%	5,427	5,427	2
3	V	32	Interest Expense		Rock River Health Care Realty LLC	100.00%	257,815	257,815	3
4	V	33	Real Estate Taxes	85,670	Rock River Health Care Realty LLC	100.00%	85,670		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 720,314			$ 348,912	$ * (371,402)	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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	02	Food	$	Premier Healthcare & Financial Services	100.00%	$ 788	$ 788	15
16	V	03	Housekeeping		Premier Healthcare & Financial Services	100.00%	1,554	1,554	16
17	V	05	Utilities		Premier Healthcare & Financial Services	100.00%	987	987	17
18	V	06	Repairs & Maintenance		Premier Healthcare & Financial Services	100.00%	1,458	1,458	18
19	V	17	Administrative Expenses		Premier Healthcare & Financial Services	100.00%	32,619	32,619	19
20	V	19	Professional Fees		Premier Healthcare & Financial Services	100.00%	607	607	20
21	V	20	Dues & Subscriptions		Premier Healthcare & Financial Services	100.00%	155	155	21
22	V	21	Clerical & General Salaries		Premier Healthcare & Financial Services	100.00%	52,090	52,090	22
23	V	21	Clerical & General Other Costs		Premier Healthcare & Financial Services	100.00%	2,952	2,952	23
24	V	24	Seminar & Education		Premier Healthcare & Financial Services	100.00%	345	345	24
25	V	26	Insurance		Premier Healthcare & Financial Services	100.00%	292	292	25
26	V	27	Employee Benefits		Premier Healthcare & Financial Services	100.00%	13,277	13,277	26
27	V	34	Rent Expense		Premier Healthcare & Financial Services	100.00%	12,341	12,341	27
28	V	17	Consulting Fees	118,500	Premier Healthcare & Financial Services	100.00%		(118,500)	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			$ 118,500			$ 119,465	$ * 965	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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Premier Healthcare Real Estate	100.00%	$ 54	$ 54	15
16	V	20	Dues & Subscriptions		Premier Healthcare Real Estate	100.00%	4	4	16
17	V	32	Interest Expense		Premier Healthcare Real Estate	100.00%	981	981	17
18	V	33	Real Estate Taxes		Premier Healthcare Real Estate	100.00%	2,175	2,175	18
19	V	34	Rental Income	3,914	Premier Healthcare Real Estate	100.00%		(3,914)	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			$ 3,914			$ 3,214	$ * (700)	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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Salary	$ 95,355	SABA Healthcare	100.00%	$ 4,086	$ (91,269)	15
16	V	15	Nursing Employee Benefits		SABA Healthcare	100.00%	1,041	1,041	16
17	V	17	Admin Salary- Related		SABA Healthcare	100.00%	57,554	57,554	17
18	V	17	Admin Salary- Non Related		SABA Healthcare	100.00%	12,258	12,258	18
19	V	19	Professional Fees		SABA Healthcare	100.00%	197	197	19
20	V	21	Admin & General Expenses		SABA Healthcare	100.00%	783	783	20
21	V	21	Admin & General Salary		SABA Healthcare	100.00%	14,230	14,230	21
22	V	24	Seminar & Education		SABA Healthcare	100.00%	2,324	2,324	22
23	V	25	Auto & Travel		SABA Healthcare	100.00%	1,070	1,070	23
24	V	27	Employee Benefits- Admin		SABA Healthcare	100.00%	9,519	9,519	24
25	V	17	Consulting Fees	118,500	SABA Healthcare	100.00%		(118,500)	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			$ 213,855			$ 103,062	$ * (110,793)	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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	17.50%	Center Home Hispanic Elderly	Chicago	RR Healthcare Realty	Rockford	Building Co	1
2	Yeruchom Levovitz	14.42%	Pine Crest Health Care	Hazel Crest	Premier HC & Financi	Skokie	Consulting Co	2
3	Moshe Levovitz	1.54%	Park View Rehab Center	Chicago	Premier HC Realty	Skokie	Building Co	3
4	CTCAAR LLC	1.54%	River View Rehab Center	Elgin	SABA Healthcare	Skokie	Consulting Co	4
5	Kevin Chankin	2.50%	Forest City Rehab & Nursing	Rockford				5
6	Aaron Singer	13.25%	Pearl Pavilion	Freeport				6
7	Benzion Fishbane	1.00%	Prairie Oasis	South Holland				7
8	Moshe Blonder	13.25%	Oak Park Oasis	Oak Park				8
9	ATIED Associates LLC	20.00%	Austin Oasis	Chicago				9
10	SMF Healthcare LLC	15.00%	Briar Place Nursing	Indian Head Park				10
11			Arista Healthcare	Naperville				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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Member	Administrative	17.50%	See Attachment	2.17	5.44%	Alloc Salary	$ 10,873	17-7	1
2	Yeruchom Levovitz	Member	Administrative	14.42%	See Attachment	2.17	5.44%	Alloc Salary	10,873	17-7	2
3	Kevin Chankin	Member	Clerical	2.50%	See Attachment	2.17	5.44%	Alloc Salary	10,873	17-7	3
4	Jake Singer	Relative	Administrative	0.00%	See Attachment	4.67	11.67%	Alloc Sal/Sal	15,766	17-1; 17-7	4
5	Moshe Blonder	Member	Administrative	13.25%	See Attachment	4.67	11.67%	Alloc Pymt	23,348	17-7	5
6	Aaron Singer	Member	Administrative	13.25%	See Attachment	4.67	11.67%	Alloc Pymt	23,348	17-7	6
7											7
8											8
9											9
10											10
11											11
12	As necessary, the amounts reported above have been adjusted to reflect only HFS allowable costs										12
13								TOTAL	$ 95,081		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: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	02	Food	Resident Days	427,478	10	$ 14,500	$	23,240	$ 788	1
2	03	Housekeeping	Resident Days	427,478	10	28,586		23,240	1,554	2
3	05	Utilities	Resident Days	427,478	10	18,155		23,240	987	3
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817		23,240	1,458	4
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	23,240	32,619	5
6	19	Professional Fees	Resident Days	427,478	10	11,167		23,240	607	6
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851		23,240	155	7
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	23,240	52,090	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299		23,240	2,952	9
10	24	Seminar & Education	Resident Days	427,478	10	6,339		23,240	345	10
11	26	Insurance	Resident Days	427,478	10	5,376		23,240	292	11
12	27	Employee Benefits	Resident Days	427,478	10	244,216		23,240	13,277	12
13	34	Rent Expense	Resident Days	427,478	10	227,000		23,240	12,341	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,197,453	$ 1,558,147		$ 119,465	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Resident Days	427,478	10	$ 1,000	$	23,240	$ 54	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75		23,240	4	2
3	32	Interest Expense	Resident Days	427,478	10	18,053		23,240	981	3
4	33	Real Estate Taxes	Resident Days	427,478	10	40,000		23,240	2,175	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 59,128	$		$ 3,214	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SABA Healthcare
Street Address: 3515 Howard Street, Suite 1001
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 383-9104
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	10	Nursing Salary	Resident Days	199,072	5	$ 35,000	$ 35,000	23,240	$ 4,086	1
2	15	Nursing Employee Benefits	Resident Days	199,072	5	8,921		23,240	1,041	2
3	17	Admin Salary- Related	Resident Days	199,072	5	493,000	93,000	23,240	57,554	3
4	17	Admin Salary- Non Related	Resident Days	199,072	5	105,000	105,000	23,240	12,258	4
5	19	Professional Fees	Resident Days	199,072	5	1,689		23,240	197	5
6	21	Admin & General Expenses	Resident Days	199,072	5	6,710		23,240	783	6
7	21	Admin & General Salary	Resident Days	199,072	5	121,894	121,894	23,240	14,230	7
8	24	Seminar & Education	Resident Days	199,072	5	19,907		23,240	2,324	8
9	25	Auto & Travel	Resident Days	199,072	5	9,165		23,240	1,070	9
10	27	Employee Benefits- Admin	Resident Days	199,072	5	81,540		23,240	9,519	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					$ 882,827	$ 354,894		$ 103,062	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$ 5,292,783			$ 257,815	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				397,000			20,215	6
7	Allocated From Premier RE		X								981	7
8												8
9	TOTAL Facility Related						$	$ 5,689,783			$ 279,011	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,665)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,665)	14
15	TOTALS (line 9+line14)						$	$ 5,689,783			$ 276,346	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	78,652	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.)	$	87,840	2
3. Under or (over) accrual (line 2 minus line 1).	$	9,188	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	78,652	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	87,840	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	76,593	8
	2014	77,140	9
	2015	86,670	10
	2016	85,592	11
	2017	85,670	12

Allocated From Premier RE: $2,175

Beginning accrual adjusted

	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 Health Care COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0053231

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-304-008	Long Term Care Property	$ 85,669.54	$ 85,669.54
2.	10-23-324-047-0000	Home Office Allocation	$ 36,245.26	$ 1,970.49
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,914.80	$ 87,640.03

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 RE			1,033	2
3	TOTALS	250,035		$ 176,033	3

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2014	1977	$ 3,000,000	$	35	$ 85,714	$ 85,714	$ 428,571	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,000,000	$		$ 85,714	$ 85,714	$ 428,571	70

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

Rock River Healthcare
12/31/2018
Capital Report Reconciliation

During 2018, the 6/30/2017 capital report was finalized.

The following 2017 improvements were included on the final 6/30/2017 capital report

Page	Line	Description	Cost
12B	14	Removed/Installed New Chiller and Cooling Tower- Kitchen	$ 83,700
12B	15	Architecture Fees- Associated with Renovations	$ 8,500
12B	16	Renvated Main/2nd FL Vestibule, Resident Rooms, Dining Room	$ 845,809
12B	17	Boiler Room & West Wing Asbestos Survey, Inspection & Abatement	$ 8,255
12B	18	Title Fees	$ 2,500
12B	19	Pumps and Boilers	$ 74,340
		Total	$ 1,023,104

The following 2017 improvements were added between 7/1/17-12/31/17

Page	Line	Description	Cost
12B	20	Repair Step Leading into Basement	$ 2,500
12B	21	13 Sprinkler Heads	$ 3,728
		Total	$ 6,228
		Total 2017 Improvements	$ 1,029,332

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,000,000	$		$ 85,714	$ 85,714	$ 428,571	1
2	Security Camera- 16 Channel NVR- Dome Camera Wall Mount	2015	7,130		20	357	357	1,426	2
3	Security Camera- Wiring, Jacks, Surface Boxes, Plates	2015	13,405		20	670	670	2,681	3
4	Replaced Chiller- High Pressure Control	2015	10,959		20	548	548	2,192	4
5	Asphalt-Garbage Pad & Sidewalks(Front Prmter),Glass &Doors	2015	400,000		20	20,000	20,000	80,000	5
6	Replacement of Boiler	2015	4,448		20	222	222	890	6
7	Water System Installation, Tap Water AAMI Analysis	2016	5,665		20	283	283	850	7
8	Replace Leaking Tubes in Boiler, Re-Line Front Firebox Door	2016	3,800		20	190	190	570	8
9	Boiler Pump Replacement	2016	8,634		20	432	432	1,295	9
10	Boiler Improvments	2016	4,478		20	224	224	672	10
11	Chiller Work	2016	5,369		20	268	268	805	11
12	Set Up Temporary Carrier Chiller	2016	5,818		20	291	291	873	12
13	2016 West Wing Asbestos	2016	32,490		20	1,625	1,625	4,874	13
14	Removed/Installed New Chiller and Cooling Tower- Kitchen	2017	83,700		20	4,185	4,185	8,370	14
15	Architecture Fees- Associated with Renovations	2017	8,500		20	425	425	850	15
16	Renvated Main/2nd FL Vestibule, Resident Rooms, Dining Room	2017	845,809		20	42,290	42,290	84,581	16
17	Boiler Room & West Wing Asbestos Survey, Inspection & Abatem	2017	8,255		20	413	413	826	17
18	Title Fees	2017	2,500		20	125	125	250	18
19	Pumps and Boilers	2017	74,340		20	3,717	3,717	7,434	19
20	Repair Step Leading into Basement	2017	2,500		20	125	125	250	20
21	13 Sprinkler Heads	2017	3,728		20	186	186	373	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)		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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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15									15
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22									22
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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)		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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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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)		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,531,528	$		$ 162,291	$ 162,291	$ 628,631	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Building Company Leashold Improvements								8
9	Elevator Modernization- Tank Unit, Interiors, Doors, Pit	2018	29,500		20	1,475		1,475	9
10	Elevator- New Cab Interior	2018	13,100		20	655	655	655	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)		$ 4,574,128	$		$ 164,421	$ 162,946	$ 630,761	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,574,128	$		$ 164,421	$ 164,421	$ 630,761	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
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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)		$ 4,574,128	$		$ 164,421	$ 164,421	$ 630,761	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,574,128	$		$ 164,421	$ 164,421	$ 630,761	1
2	Related Party Building Allocations								2
3	Allocated From Premier Real Estate	2011	20,246		35	578	578	4,628	3
4	Allocated From Premier Real Estate	2012	2,578		35	74	74	516	4
5									5
6									6
7									7
8	Related Party Leasehold Improvement Allocations								8
9	Allocated From Premier HC & Financial Services	2012	459		20	23	23	161	9
10	Allocated From Premier HC & Financial Services	2016	1,076		20	54	54	161	10
11									11
12									12
13	Allocated From Premier Real Estate	2011	36,009		20	1,800	1,800	14,404	13
14	Allocated From Premier Real Estate	2012	1,044		20	52	52	365	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)		$ 4,635,540	$		$ 167,002	$ 167,002	$ 650,996	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,635,540	$		$ 167,002	$ 167,002	$ 650,996	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,635,540	$		$ 167,002	$ 167,002	$ 650,996	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: 01/01/2018 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	$ 590,195	$	$ 59,020	$ 59,020		$ 240,425	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 590,195	$	$ 59,020	$ 59,020		$ 240,425	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)	$ 5,401,768	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,021	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 226,021	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 891,421	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	Renovation of Facility	$ 494,593	92
93			93
94			94
95		$ 494,593	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.

Rock River Healthcare
12/31/2018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Rock River Healthcare	152,915		15,292	15,292	47,615
Premier Healthcare & Financial	3,998		400	400	2,623
Premier Real Estate	11,891		1,189	1,189	8,409
Rock River Realty	421,391		42,139	42,139	181,778
Total	590,195	-	59,020	59,020	240,425

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

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

Total Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Rock River Healthcare	152,915	-	15,292	15,292	47,615
Premier Healthcare & Financial	3,998	-	400	400	2,623
Premier Real Estate	11,891	-	1,189	1,189	8,409
Rock River Realty	421,391	-	42,139	42,139	181,778
Total	590,195	-	59,020	59,020	240,425

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated From Premier HC & Financial				8,427			6
7	TOTAL				$ 8,427 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

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

16. Rental Amount for movable equipment: $ 5,131 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

FACILITY NAME	**Rock River Health Care**
FACILITY NUMBER	**0053231**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

DESCRIPTION	AMOUNT
ICE MACHINE	1,380
COPIER	3,751
TOTAL	5,131

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rock River Health Care | STATE OF ILLINOIS # 0053231 | Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 115,468	$		$ 115,468	1
2	Licensed Speech and Language Development Therapist		hrs			23,565			23,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			96,617			96,617	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				35,118		35,118	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					3,323	55,608		58,930	13
14	TOTAL			$		$ 238,972	$ 90,725		$ 329,698	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	**Rock River Health Care**
FACILITY NUMBER	**0053231**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING SPECIAL SERVICES

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

DESCRIPTION	AMOUNT
OXYGEN SUPPLY	4,983
NURSING SUPPLIES	45,724
GLOVES	4,900
	-
	-
	-
	-
	-
	-
	-
	55,608

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

DESCRIPTION	AMOUNT
X-RAYS	1,348
LABORATORY	1,975
	-
	-
	-
	-
	-
	-
	-
	3,323

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

DESCRIPTION	AMOUNT
	-
	-
	-
	-
	-
	-
	-
	-

STATE OF ILLINOIS

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 79,786	$ 204,263	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,467,581	1,467,581	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	160,850	160,850	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		42,762	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,708,217	$ 1,875,456	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	44,524	1,669,174	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			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	13,483	1,107,321	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 86,237	$ 5,147,704	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,794,454	$ 7,023,161	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 570,835	$ 570,835	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	397,000	397,000	29
30	Accrued Salaries Payable	156,190	156,190	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,467	6,467	31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,652	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	30,143	30,143	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,160,635	$ 1,239,287	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,292,783	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	763,000	1,273,270	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 763,000	$ 6,566,053	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,923,635	$ 7,805,340	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (129,181)	$ (782,180)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,794,454	$ 7,023,161	48

*(See instructions.)

FACILITY NAME	**Rock River Health Care**
FACILITY NUMBER	**0053231**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
REAL ESTATE TAX ESCROW		42,762
	-	42,762

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
ACCRUED BED TAX	6,726	6,726
DUE TO PRIOR OWNER	6,755	6,755
DUE ON COST REPORT	16,662	16,662
	30,143	30,143

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

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM OTHERS	13,365	13,365
DUE FROM AFFILIATES	118	118
CIP		494,593
CD- RESERVE ON MORTGAGE		500,564
ORGANIZATIONAL COSTS		81,784
A/A- ORGANIZATIONAL COSTS		(13,103)
DUE TO RR HEALTHCARE		30,000
	13,483	1,107,321

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

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO RELATED PARTY	325,000	325,000
DUE TO OTHERS	438,000	948,270
	763,000	1,273,270

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 200,319	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt & Journal Entries**	(74,766)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 125,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(254,734)	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)**	$ (254,734)	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)**	$ (129,181)	24 *

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,393,407	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,393,407	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	624	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 624	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,665	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,665	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	131,038	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 131,038	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,527,734	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	728,174	31
32	Health Care	1,687,784	32
33	General Administration	1,084,864	33
	B. Capital Expense		
34	Ownership	745,655	34
	C. Ancillary Expense		
35	Special Cost Centers	332,096	35
36	Provider Participation Fee	203,895	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,782,468	40
41	**Income before Income Taxes (line 30 minus line 40)****	(254,734)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (254,734)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,921,389	44
45	Private Pay - Net Inpatient Revenue	83,666	45
46	Medicare - Net Inpatient Revenue	869,932	46
47	Other-(specify) Hospice	395,948	47
48	Other-(specify) Commercial	122,472	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,393,407	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	**Rock River Health Care**
FACILITY NUMBER	**0053231**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

DESCRIPTION	AMOUNT
MEDICAID W/O CO-INSURANCE	129,003
VENDING INCOME (ADJ PG 5A)	530
MISCELLANEOUS INCCOME (ADJ PG 5A)	1,445
MEDICAL RECORDS INCOME (ADJ PG 5A)	60
TOTAL	131,038

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,104	$ 89,449	$ 42.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,814	7,129	226,266	31.74	3
4	Licensed Practical Nurses	12,076	12,881	380,057	29.51	4
5	CNAs & Orderlies	41,390	45,069	594,403	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,824	2,080	30,831	14.82	9
10	Activity Assistants	2,929	3,386	33,387	9.86	10
11	Social Service Workers	4,020	4,251	99,086	23.31	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	62,723	30.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,177	13,272	153,546	11.57	15
16	Dishwashers					16
17	Maintenance Workers	1,814	1,911	29,412	15.39	17
18	Housekeepers	10,064	11,106	130,140	11.72	18
19	Laundry	3,000	3,226	28,294	8.77	19
20	Administrator	1,842	1,842	76,514	41.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,796	6,260	90,144	14.40	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	1,912	2,079	24,653	11.86	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached					33
34	TOTAL (lines 1 - 33)	109,626	118,676	$ 2,048,906 *	$ 17.26	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	126	$ 6,768	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant			10-03	37
38	Nurse Consultant	Monthly	95,355	10-03	38
39	Pharmacist Consultant	Monthly	3,900	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant			11-03	44
45	Social Service Consultant	35	2,259	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	1,372	68,530	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,533	$ 184,012		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: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roland Arreguin	Administrator	0.00%	$ 41,624
Qirjako Kirk Hoda	Administrative	0.00%	19,399
Heath Schiesher	Administrative	0.00%	10,582
Jake Singer	Administrative	0.00%	4,909
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,514

B. Administrative - Other

Description	Amount
Consulting Fees- Premier HC & Financial Services	$ 118,500
Consulting Fees- Saba Healthcare	118,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 237,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 26,950
Marcum	Accounting	16,179
Prospect Resources	Energy Consulting	600
Mowery & Schoenfeld	Accounting	2,026
Reliable Health Systems	Data Processing	12,120
Creative Tech Solutions	IT Support	9,091
Point Click Care	Data Processing	17,403
Streamlined HR	HR Consulting	182
Zirmed	Data Processing- Claims Mgmt	575
Experian	Computer Services	127
Ability Network	Data Processing- Claims Mgmt	1,767
See Attached		4,561
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 91,581

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,326
Unemployment Compensation Insurance	53,326
FICA Taxes	155,481
Employee Health Insurance	33,311
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Expenses	5,026
Holiday Expense	2,500
TOTAL (agree to Schedule V, line 22, col.8)	$ 288,970

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,560
Health Care Worker Background Check	3,417
(Indicate # of checks performed 342)	
Patient Background Checks	
Dues	10,524
Licenses & Fees	1,608
Allocated From Premier HC & Financial	155
Allocated From Premier RE	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,912
Allocated From Premier HC & Financial	345
Allocated From Saba HC	2,324
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,581

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
	$

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

C. Professional Services

Vendor/Payee	Type	Amount
Aatrix	Electronic Forms Consulting	$ 61
Assurance Agency	Safety Services Consulting	4,500

TOTAL (agree to Schedule V, line 19, column 3) $ 4,561
(For legal fee disclosure, see page 39 of instructions)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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

Description	Line #	Amount
		$

TOTAL $

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

* Attach copy of IMRF notifications

**See instructions.

Rock River Health Care
Detail of Legal Expense
12/31/2018

GL Account	Date	Vendor	Description of Service	Amount	Adjustment	Allowable
8380.6	7/20/2017	Field & Goldberg	Prior Year Legal Services	840.00	(840.00)	-
8380.6	7/10/2018	Field & Goldberg	Loan Modification	1,165.00	(1,165.00)	-
8380.6	9/21/2018	Field & Goldberg	Loan Modification	1,165.00	(1,165.00)	-
8380.6	5/10/2017	Neal Gerber & Eisenberg	Prior Year Legal Services	49.05	(49.05)	-
8380.6	1/31/2018	Neal Gerber & Eisenberg	General Employment Matters	599.50	-	599.50
8380.6	2/6/2018	Charles Silverman	Litigation- Transitions	3,312.00	-	3,312.00
8380.6	9/27/2018	Charles Silverman	Litigation- Transitions	2,000.00	-	2,000.00
8380.6	11/22/2017	SB2	Prior Year Legal Services	571.43	(571.43)	-
8380.6	12/12/2017	SB2	Prior Year Legal Services	214.29	(214.29)	-
8380.6	12/13/2017	SB2	Prior Year Legal Services	220.63	(220.63)	-
8380.6	12/31/2017	SB2	Prior Year Legal Services	571.42	(571.42)	-
8380.6	1/22/2018	SB2	Monthly PA Review	550.00		550.00
8380.6	1/2/2018	SB2	Monthly PA Review	192.36		192.36
8380.6	2/14/2018	SB2	Monthly PA Review	506.25		506.25
8380.6	3/1/2018	SB2	Monthly PA Review	187.50		187.50
8380.6	7/31/2018	Polsinelli	Managed Care Contracts/Hospice Litigation	1,465.20		1,465.20
8380.6	7/31/2018	Polsinelli	Managed Care Contracts/Hospice Litigation	6,123.99	(508.32)	5,615.67
8380.6	10/31/2018	Polsinelli	Managed Care Contracts/Hospice Litigation	1,207.60		1,207.60
8380.6	11/14/2018	Schueler Davalli Casieri	Refund of Legal Services- Claims	(6,491.50)		(6,491.50)
8420.6	11/12/2018	Oliver Close	General Counseling	12,500.00	-	12,500.00
				26,949.72	(5,305.14)	21,644.58

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $21,047**

(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. $ **16,113** 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. $ **203,895**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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