		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0053231

Facility Name: Rock River Health Care

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

County: Winnebago

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) 05/06/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 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	25,254	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,326	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	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			2,828	2,828	8
9	SNF/PED					9
10	ICF	19,542	337	2,801	22,680	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,542	337	5,629	25,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.61%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 69 and days of care provided 2,828

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	235,454	20,008	6,768	262,230		262,230		262,230			1
2	Food Purchase		150,144		150,144		150,144	(20)	150,124			2
3	Housekeeping	82,083	14,367		96,450		96,450	1,962	98,412			3
4	Laundry	55,059	10,521	258	65,838		65,838		65,838			4
5	Heat and Other Utilities			101,409	101,409		101,409	(4,945)	96,464			5
6	Maintenance	75,366	20,317	46,090	141,773		141,773	4,136	145,909			6
7	Other (specify):*							45	45			7
8	**TOTAL General Services**	447,962	215,357	154,525	817,844		817,844	1,178	819,022			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,560,425	148,583	196,735	1,905,743		1,905,743	(103,412)	1,802,331			10
10a	Therapy											10a
11	Activities	75,480	1,463		76,943		76,943		76,943			11
12	Social Services	91,390		3,181	94,571		94,571		94,571			12
13	CNA Training											13
14	Program Transportation			315	315		315		315			14
15	Other (specify):*							1,658	1,658			15
16	**TOTAL Health Care and Programs**	1,727,295	150,046	209,831	2,087,172		2,087,172	(101,754)	1,985,418			16
	C. General Administration											
17	Administrative	90,247		340,000	430,247		430,247	(198,669)	231,578			17
18	Directors Fees											18
19	Professional Services			150,280	150,280	(576)	149,704	(80,981)	68,723			19
20	Dues, Fees, Subscriptions & Promotions			35,920	35,920		35,920	(13,210)	22,710			20
21	Clerical & General Office Expenses	98,144		164,008	262,152		262,152	(63,452)	198,700			21
22	Employee Benefits & Payroll Taxes			406,723	406,723		406,723	(83,382)	323,341			22
23	Inservice Training & Education											23
24	Travel and Seminar			366	366		366	3,831	4,197			24
25	Other Admin. Staff Transportation			1,231	1,231		1,231	1,683	2,914			25
26	Insurance-Prop.Liab.Malpractice			186,868	186,868		186,868	860	187,728			26
27	Other (specify):*							33,899	33,899			27
28	**TOTAL General Administration**	188,391		1,285,396	1,473,787	(576)	1,473,211	(399,420)	1,073,790			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,363,648	365,403	1,649,752	4,378,803	(576)	4,378,227	(499,996)	3,878,230			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: 01/01/20 Ending: 12/31/20

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			12,188	12,188		12,188	210,783	222,971			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,969	4,969		4,969	218,195	223,164			32
33	Real Estate Taxes					576	576	90,682	91,259			33
34	Rent-Facility & Grounds			791,588	791,588		791,588	(791,588)				34
35	Rent-Equipment & Vehicles			4,408	4,408		4,408		4,408			35
36	Other (specify):*											36
37	**TOTAL Ownership**			813,153	813,153	576	813,729	(271,928)	541,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	7,585	48,046	257,187	312,818		312,818		312,818			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,272	226,272		226,272	(10,744)	215,528			42
43	Other (specify):*			3,167	3,167		3,167	(3,167)				43
44	**TOTAL Special Cost Centers**	7,585	48,046	486,626	542,257		542,257	(13,911)	528,346			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,371,233	413,449	2,949,531	5,734,213		5,734,213	(785,835)	4,948,378			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: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	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	(6,212)	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	210,783	30		9
10	Interest and Other Investment Income	(5,318)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(897)	21		18
19	Entertainment				19
20	Contributions	(1,278)	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	(110,733)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(111)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(159,523)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,309)		$	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)	(712,526)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (712,526)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (785,835)		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: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (8,913)	21	1
2	Sequestration Expense	(32,123)	21	2
3	Miscellaneous Income	(8,242)	21	3
4	Marketing Expense	(3,167)	43	4
5	Building Co. - Professional Fees	(2,800)	19	5
6	Non-Allowable Legal	(53)	19	6
7	Additional R&M	2,321	06	7
8	PAC Dues	(11,986)	20	8
9	Prior Period Miscellaneous Expense	(434)	21	9
10	Prior Period Employee Vacation Expense	(83,382)	22	10
11	Prior Period Bed Tax	(10,744)	42	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**	(159,523)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Rock River Health Care

IDF 0053231

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(20)											(20)	2
3	Housekeeping			1,962									1,962	3
4	Laundry													4
5	Heat and Other Utilities	(6,212)		1,267									(4,945)	5
6	Maintenance	2,321		1,436		379							4,136	6
7	Other (specify):*					45							45	7
8	**TOTAL General Services**	(3,911)		4,665		424							1,178	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(3,623)			(99,789)				(103,412)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					111			1,547				1,658	15
16	**TOTAL Health Care and Programs**					(3,512)			(98,242)				(101,754)	16
	C. General Administration													
17	Administrative			(91,040)		606			(108,235)				(198,669)	17
18	Directors Fees													18
19	Professional Services	(2,853)	2,800	(82,027)	761	45			293				(80,981)	19
20	Fees, Subscriptions & Promotions	(13,264)		53		1							(13,210)	20
21	Clerical & General Office Expenses	(161,453)	(9,140)	83,142		1,685			22,315				(63,452)	21
22	Employee Benefits & Payroll Taxes	(83,382)											(83,382)	22
23	Inservice Training & Education													23
24	Travel and Seminar			374		3			3,454				3,831	24
25	Other Admin. Staff Transportation					93			1,590				1,683	25
26	Insurance-Prop.Liab.Malpractice			808		52							860	26
27	Other (specify):*			19,485		265			14,149				33,899	27
28	**TOTAL General Administration**	(260,952)	(6,340)	(69,205)	761	2,750			(66,434)				(399,420)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(264,863)	(6,340)	(64,540)	761	(338)			(164,676)				(499,996)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock River Health Care # 0053231 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	210,783											210,783	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,318)	219,740	3	1,086		2,684						218,195	32
33	Real Estate Taxes		85,769		1,251		3,663						90,682	33
34	Rent-Facility & Grounds		(791,588)	14,294	(6,191)		(8,102)						(791,588)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	205,465	(486,079)	14,297	(3,854)		(1,756)						(271,928)	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	(10,744)											(10,744)	42
43	Other (specify):*	(3,167)											(3,167)	43
44	TOTAL Special Cost Centers	(13,911)											(13,911)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(73,309)	(492,419)	(50,244)	(3,093)	(338)	(1,756)		(164,676)				(785,835)	45

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 791,588	Rock River Health Care Realty LLC		$	$ (791,588)	1
2	V	19	Professional Fees		Rock River Health Care Realty LLC		2,800	2,800	2
3	V	32	Interest		Rock River Health Care Realty LLC		219,740	219,740	3
4	V	33	Real Estate Taxes		Rock River Health Care Realty LLC		85,769	85,769	4
5	V	21	Miscellaneous Income	9,140	Rock River Health Care Realty LLC			(9,140)	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			$ 800,728			$ 308,309	$ * (492,419)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	17.50%	AUSTIN OASIS	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	CONSULTING CO	1
2	Yeruchom Levovitz	14.42%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO	2
3	Moshe Levovitz	1.54%	OAK PARK OASIS	HAZEL CREST	SABA HEALTHCARE	SKOKIE, IL	CONSULTING CO	3
4	CTCAAR LLC	1.54%	PARK VIEW REHAB CENTER	ELGIN	ROCK RIVER HC REALTY	ROCKFORD, IL	BUILDING CO	4
5	Kevin Chankin	2.50%	PINE CREST HEALTH CARE	ROCKFORD	ICARE HEALTH SERVICES INC	BURLINGTON, VT	INSURANCE	5
6	Aharon Singer	13.25%	PRARIE OASIS	FREEPORT	8131 MONTICELLO REALTY, LI	SKOKIE, IL	BUILDING CO	6
7	BBF Investments LP	1.00%	RIVER VIEW REHAB CENTER	ELGIN	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING CO	7
8	Moshe Blonder	13.25%	FOREST CITY REHAB & NURSING	ROCKFORD				8
9	ATIED Associates LLC	20.00%	PEARL PAVILION	FREEPORT				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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	3	HOUSEKEEPING	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		$ 1,962	$ 1,962	15
16	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,267	1,267	16
17	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,436	1,436	17
18	V	17	ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		36,960	36,960	18
19	V	19	PROFESSIONAL FEES	84,000	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,973	(82,027)	19
20	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		53	53	20
21	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4,656	4,656	21
22	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		78,486	78,486	22
23	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		374	374	23
24	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		808	808	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		19,485	19,485	25
26	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3	3	26
27	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		14,294	14,294	27
28	V	17	CONSULTING FEES	128,000	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(128,000)	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			$ 212,000			$ 161,756	$ * (50,244)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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			$			$	$	15
16	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		761	761	16
17	V	20	LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30	DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32	INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		1,086	1,086	19
20	V	33	REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		1,251	1,251	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	6,191	PREMIER HEALTHCARE REALTY, LLC			(6,191)	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			$ 6,191			$ 3,099	$ * (3,093)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	6	REPAIRS AND MAINTENANCE	$	ICARE CONSULTING SERVICES LLC		$ 379	$ 379	15
16	V	7	R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		45	45	16
17	V	10	NURSING SALARIES	4,500	ICARE CONSULTING SERVICES LLC		877	(3,623)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		111	111	18
19	V	17	ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		606	606	19
20	V	19	PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		45	45	20
21	V	20	DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		1	1	21
22	V	21	CLERICAL AND GENERAL		ICARE CONSULTING SERVICES LLC		55	55	22
23	V	21	CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		1,630	1,630	23
24	V	24	SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		3	3	24
25	V	25	AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		93	93	25
26	V	26	INSURANCE		ICARE CONSULTING SERVICES LLC		52	52	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		265	265	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,500			$ 4,162	$ * (338)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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	19	PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20	LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30	DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32	INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		2,684	2,684	19
20	V	33	REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		3,663	3,663	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	8,102	8131 MONTICELLO REALTY, LLC			(8,102)	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			$ 8,102			$ 6,346	$ * (1,756)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	26	INSURANCE	$ 65,163	ICARE HEALTH SERVICES INCORPORATED CELL		$ 65,163	$	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			$ 65,163			$ 65,163	$ *	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 105,862	SABA HEALTHCARE		$ 6,073	$ (99,789)	15
16	V	15	NURSING EMPLOYEE BENEFITS		SABA HEALTHCARE		1,547	1,547	16
17	V	17	ADMIN SALARY - RELATED		SABA HEALTHCARE		85,545	85,545	17
18	V	17	ADMIN SALARY - NON RELATED		SABA HEALTHCARE		18,220	18,220	18
19	V	19	PROFESSIONAL FEES		SABA HEALTHCARE		293	293	19
20	V	21	ADMIN & GENERAL EXPENSES		SABA HEALTHCARE		1,164	1,164	20
21	V	21	ADMIN & GENERAL SALARY		SABA HEALTHCARE		21,151	21,151	21
22	V	24	SEMINAR & EDUCATION		SABA HEALTHCARE		3,454	3,454	22
23	V	25	AUTO & TRAVEL		SABA HEALTHCARE		1,590	1,590	23
24	V	27	EMPLOYEE BENEFITS - ADMIN		SABA HEALTHCARE		14,149	14,149	24
25	V	17	CONSULTING FEES	212,000	SABA HEALTHCARE			(212,000)	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			$ 317,862			$ 153,186	$ * (164,676)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	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 Attached	2.85	7.12%	Alloc Salary	$ 9,910	17-7	1
2	Yeruchem Levovitz	Member	Administrative	14.42%	See Attached	2.85	7.12%	Alloc Salary	9,258	17-7	2
3	Kevin Chankin	Member	Administrative	2.50%	See Attached	2.85	7.12%	Alloc Salary	17,792	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 36,960		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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HEALTHCARE & FINANCIAL
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 945-6107

	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	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	$ 27,572	$	25,522	$ 1,962	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798		25,522	1,267	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184		25,522	1,436	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	25,522	36,960	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719		25,522	1,973	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738		25,522	53	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	25,522	4,656	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850		25,522	78,486	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249		25,522	374	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347		25,522	808	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803		25,522	19,485	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39		25,522	3	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851		25,522	14,294	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,272,926	$ 1,622,196		$ 161,756	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HEALTHCARE REALTY, LLC
Street Address: 8153 LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700		25,522	761	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			25,522		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			25,522		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267		25,522	1,086	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,579		25,522	1,251	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 43,546	$		$ 3,099	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	$ 145,610	$ 145,409	4,500	$ 379	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		4,500	45	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	4,500	877	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		4,500	111	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	4,500	606	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		4,500	45	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		4,500	1	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		4,500	55	8
9	21	CLERICAL & GENERAL WAGI	CONSULTING FEES	1,730,000	8	626,600	626,600	4,500	1,630	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		4,500	3	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		4,500	93	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		4,500	52	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		4,500	265	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,599,973	$ 1,341,950		$ 4,162	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8			25,522		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			25,522		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			25,522		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708		25,522	2,684	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468		25,522	3,663	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 89,176	$		$ 6,346	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	26	INSURANCE	DIRECT ALLOCATION			$	$		$ 65,163	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					$	$		$ 65,163	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	DIRECT			$	$		$ 6,073	1
2	15	NURSING EMPLOYEE BENEFI	DIRECT						1,547	2
3	17	ADMIN SALARY - RELATED	DIRECT						85,545	3
4	17	ADMIN SALARY - NON RELAT	DIRECT						18,220	4
5	19	PROFESSIONAL FEES	DIRECT						293	5
6	21	ADMIN & GENERAL EXPENSE	DIRECT						1,164	6
7	21	ADMIN & GENERAL SALARY	DIRECT						21,151	7
8	24	SEMINAR & EDUCATION	DIRECT						3,454	8
9	25	AUTO & TRAVEL	DIRECT						1,590	9
10	27	EMPLOYEE BENEFITS - ADMI	DIRECT						14,149	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					$	$		$ 153,186	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$ 4,476,077			$ 219,740	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit							4,969	6
7	Allocated from Premier HC		X								3	7
8	See Supplemental Schedule										3,770	8
9	TOTAL Facility Related						$	$ 4,476,077			$ 228,482	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,318)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,318)	14
15	TOTALS (line 9+line14)						$	$ 4,476,077			$ 223,164	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: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	90,682	2
3. Under or (over) accrual (line 2 minus line 1).	$	90,682	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	576	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.	$	91,258	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	86,670	8
	2016	85,592	9
	2017	85,670	10
	2018	86,099	11
	2019	85,769	12

Facility Does Not Accrue RE Taxes
Allocated From Premier RE = $1,251
Allocated From 8131 Monticello = $3,663

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock River Health Care COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0053231

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-304-008	Long Term Care Property	$ 85,768.62	$ 85,768.62
2.	10-23-324-045-0000	Allocated from 8131 Monticello Realt	$ 51,467.63	$ 3,662.75
3.	10-23-324-047-0000	Allocated from Premier Healthcare	$ 34,381.62	$ 2,446.80
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 171,617.87	$ 91,878.17

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock River Health Care COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0053231

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	see attached related parties allocation		see attached	4,786	2
3	TOTALS	250,035		$ 179,786	3

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 599,999	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2015	35,942		20	1,797	1,797	10,048	9
10	Various			2016	33,764		20	1,688	1,688	8,030	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,520,244			76,012	76,012	340,986	67
68	Related Party Allocations (Pages 12H & 12I)		138,765			5,047	5,047	31,373	68
69	Financial Statement Depreciation			12,188			(12,188)		69
70	TOTAL (lines 4 thru 69)		$ 4,728,715	$ 12,188		$ 170,259	$ 158,071	$ 990,437	70

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,728,715	$ 12,188		$ 170,259	$ 158,071	$ 990,437	1
2	Repair Step Leading Into Basement	2017	2,500		20	125	125	479	2
3	13 Sprinkler Heads	2017	3,728		20	186	186	699	3
4	Repaired Ductile Iron Leaks	2019	7,200		20	360	360	630	4
5	Repair Leaking Pipes	2019	2,821		20	141	141	282	5
6	Install 22 Commercial Sd Modulators	2020	4,200		20	210	210	210	6
7	Installation Of New Call Light System For 25 Rooms	2020	21,001		20	1,050	1,050	1,050	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)		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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)		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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)		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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)		$ 4,770,164	$ 12,188		$ 172,331	$ 160,143	$ 993,787	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Asphalt-Garbage Pad & Sidewalks (front),Glass/Doors-Entrance,S	2015	400,000		20	20,000	20,000	120,000	9
10	2016 West Wing Asbestos	2016	32,490		20	1,625	1,625	8,123	10
11	Removed/installed new Chiller and Cooling Tower - Kitchen	2017	83,700		20	4,185	4,185	16,740	11
12	Architecture Fees- Associated with Renovations	2017	8,500		20	425	425	1,700	12
13	Renovated Main/2nd Fl vestibule,resident rooms,dining room,offic	2017	845,809		20	42,290	42,290	169,162	13
14	Boiler Room & West Wing Asbestos Survey, Inspection & Abatem	2017	8,255		20	413	413	1,651	14
15	Title Fees	2017	2,500		20	125	125	1,250	15
16	Pumps and Boilers	2017	74,340		20	3,717	3,717	14,868	16
17	Elevator Modernization-Tank Unit, Interiors, Doors, Pit	2018	29,500		20	1,475	1,475	4,425	17
18	Elevator-New Cab Interior	2018	13,100		20	655	655	1,965	18
19	Architecture Design Fees - associated with main/2nd fl renovations	2020	22,050		20	1,103	1,103	1,103	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)		$ 1,520,244	$		$ 76,012	$ 76,012	$ 340,986	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,520,244	$		$ 76,012	$ 76,012	$ 340,986	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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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)		$ 1,520,244	$		$ 76,012	$ 76,012	$ 340,986	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	26,503		20	757	757	6,877	3
4	Allocated Premiere Healthcare Realty, LLC	2012	3,374		20	96	96	868	4
5	Allocated from 8131 N. Monticello	2019	58,374		20	1,668	1,668	3,336	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier HC & Financial Services	2012	601		20	30	30	271	9
10	Allocated from Premier HC & Financial Services	2016	1,409		20	70	70	352	10
11									11
12	Allocated Premiere Healthcare Realty, LLC	2011	47,137		20	2,357	2,357	19,054	12
13	Allocated Premiere Healthcare Realty, LLC	2012	1,366		20	68	68	615	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)		$ 138,765	$		$ 5,047	$ 5,047	$ 31,373	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 138,765	$		$ 5,047	$ 5,047	$ 31,373	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 138,765	$		$ 5,047	$ 5,047	$ 31,373	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 505,422	$	$ 47,979	$ 47,979	10	$ 343,864	71
72	Current Year Purchases	26,617		2,662	2,662	10	2,662	72
73	Fully Depreciated Assets	7,919				10	7,919	73
74								74
75	TOTALS	$ 539,957	$	$ 50,641	$ 50,641		$ 354,444	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)	$ 5,489,908	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,188	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 222,971	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 210,783	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,348,231	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

16. Rental Amount for movable equipment: $ 4,407 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 122,458	$		$ 122,458	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			24,992			24,992	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			102,465			102,465	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				47,379		47,379	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			7,585		7,272	667		15,524	13
14	TOTAL			$ 7,585		$ 257,187	$ 48,046		$ 312,818	14

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

STATE OF ILLINOIS

Facility Name & ID Number Rock River Health Care **#** 0053231 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/20 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,845,950	$ 2,187,677	1
2	Cash-Patient Deposits	556	556	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,057,144	1,057,144	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	323,894	323,894	6
7	Other Prepaid Expenses	15,900	43,900	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		36,419	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,243,444	$ 3,649,590	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	61,815	1,411,364	15
16	Equipment, at Historical Cost	118,517	1,468,866	16
17	Accumulated Depreciation (book methods)	(107,324)	(1,995,884)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		17,431	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,206)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		558,356	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 73,008	$ 3,887,986	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,316,452	$ 7,537,576	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,190,338	$ 1,190,338	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,446	17,446	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,466	109,466	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,264	2,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,248,517	1,749,647	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,568,031	$ 3,069,161	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,476,077	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,615	2,615	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,615	$ 4,478,692	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,570,646	$ 7,547,853	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 745,806	$ (10,277)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,316,452	$ 7,537,576	48

***(See instructions.)**

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (283,973)	1
2	Restatements (describe):		2
3	Sequestration	(3,118)	3
4	Rounding	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (287,087)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,032,893	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,032,893	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)**	$ 745,806	24 *

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

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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	$ 5,837,194	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,837,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	37,557	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 37,557	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,318	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	887,037	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 887,037	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,767,106	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	817,844	31
32	Health Care	2,087,172	32
33	General Administration	1,473,787	33
	B. Capital Expense		
34	Ownership	813,153	34
	C. Ancillary Expense		
35	Special Cost Centers	315,985	35
36	Provider Participation Fee	226,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,734,213	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,032,893	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,032,893	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,585,891	44
45	Private Pay - Net Inpatient Revenue	69,678	45
46	Medicare - Net Inpatient Revenue	1,654,043	46
47	Other-(specify) Hospice	509,950	47
48	Other-(specify) Insurance	17,632	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,837,194	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,751	1,846	$ 85,234	$ 46.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,069	7,454	252,656	33.90	3
4	Licensed Practical Nurses	14,857	15,665	483,095	30.84	4
5	CNAs & Orderlies	47,757	50,356	714,685	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,059	35,411	17.20	9
10	Activity Assistants	4,345	4,581	40,069	8.75	10
11	Social Service Workers	3,685	3,886	91,390	23.52	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,052	69,692	33.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,357	13,029	165,762	12.72	15
16	Dishwashers					16
17	Maintenance Workers	3,979	4,196	75,366	17.96	17
18	Housekeepers	6,388	6,736	82,083	12.19	18
19	Laundry	4,741	4,999	55,059	11.01	19
20	Administrator	1,674	1,766	90,247	51.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,620	5,925	98,144	16.56	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	1,228	1,294	24,755	19.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	668	704	7,585	10.77	33
34	TOTAL (lines 1 - 33)	120,019	126,548	$ 2,371,233 *	$ 18.74	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	9,600	09-03	36
37	Medical Records Consultant	Monthly	1,376	10-03	37
38	Nurse Consultant	Monthly	111,800	10-03	38
39	Pharmacist Consultant	Monthly	4,245	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	47	3,181	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	950	47,465	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,124	$ 184,435		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	1,274	31,849	10-03	52
53	TOTAL (lines 50 - 52)	1,274	$ 31,849		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roland Arreguin	Administrator	0	$ 90,247
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,247

B. Administrative - Other

Description	Amount
Consulting Fees - Saba Healthcare	$ 212,000
Consulting Fees - Premier Healthcare & Financial	128,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 340,000

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 15,900
Prospect Resources	Energy Procurement	1,300
Point Click Care	Data Processing	19,794
Reliable Health Care	Data Processing	11,510
Creative Technologies	IT Support	9,264
Ability Network	Medicare Billing	1,917
Pax8, Inc.	IT Service Management	323
Sympletic Systems LLC	Data Processing	2,350
See Attached	Legal	3,282
Zirmed	Data Processing	640
Premier Healthcare	Bookkeeping Fees	84,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 150,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,727
Unemployment Compensation Insurance	21,363
FICA Taxes	181,399
Employee Health Insurance	70,505
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Expense	9,346
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,340

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	$ 3,980
Advertising: Employee Recruitment	2,250
Health Care Worker Background Check	
(Indicate # of checks performed 297)	2,968
Patient Background Checks	
Dues & Subscriptions	11,986
Licenses & Fees	1,472
See Supplemental Schedule	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	366
See Supplemental Schedule	3,831
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,197

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $23,972**

(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. $ **17,423** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **215,528**
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? **N/A** Indicate the amount. $

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.