

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Rockford 61103
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 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:

01/01/16

Ending:

12/31/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	132	131	3,841	4,104	8
9	SNF/PED					9
10	ICF	21,783	493	1,839	24,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,915	624	5,680	28,219	14

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

59.31%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold 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

3,292

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:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	242,831	14,861	7,776	265,468		265,468		265,468			1
2	Food Purchase		151,188		151,188		151,188	280	151,468			2
3	Housekeeping	198,659	15,713		214,372		214,372	966	215,338			3
4	Laundry	23,464	10,743		34,207		34,207		34,207			4
5	Heat and Other Utilities			130,434	130,434		130,434	(4,779)	125,655			5
6	Maintenance	14,688	26,034	73,301	114,023		114,023	(740)	113,283			6
7	Other (specify):*											7
8	TOTAL General Services	479,642	218,539	211,511	909,692		909,692	(4,273)	905,419			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,386,588	27,493	134,392	1,548,473		1,548,473	(6,120)	1,542,353			10
10a	Therapy	13,503			13,503		13,503		13,503			10a
11	Activities	106,875	6,669		113,544		113,544		113,544			11
12	Social Services	191,601		1,950	193,551		193,551		193,551			12
13	CNA Training											13
14	Program Transportation			329	329		329		329			14
15	Other (specify):*							7,048	7,048			15
16	TOTAL Health Care and Programs	1,698,567	34,162	143,871	1,876,600		1,876,600	928	1,877,528			16
	C. General Administration											
17	Administrative	131,802		354,500	486,302		486,302	(286,662)	199,640			17
18	Directors Fees											18
19	Professional Services			71,692	71,692	(77)	71,615	4,534	76,149			19
20	Dues, Fees, Subscriptions & Promotions			27,509	27,509		27,509	(8,258)	19,251			20
21	Clerical & General Office Expenses	65,941		105,817	171,758		171,758	(87,381)	84,377			21
22	Employee Benefits & Payroll Taxes			384,077	384,077		384,077		384,077			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,071	1,071		1,071	817	1,888			24
25	Other Admin. Staff Transportation			2,616	2,616		2,616	2,955	5,571			25
26	Insurance-Prop.Liab.Malpractice			199,946	199,946		199,946	4,852	204,798			26
27	Other (specify):*							17,479	17,479			27
28	TOTAL General Administration	197,743		1,147,228	1,344,971	(77)	1,344,894	(351,664)	993,230			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,375,952	252,701	1,502,610	4,131,263	(77)	4,131,186	(355,009)	3,776,177			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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,626	7,626		7,626	138,820	146,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,186	9,186		9,186	146,452	155,638			32
33	Real Estate Taxes			92,650	92,650	77	92,727	(3,425)	89,302			33
34	Rent-Facility & Grounds			515,333	515,333		515,333	(511,034)	4,299			34
35	Rent-Equipment & Vehicles			5,611	5,611		5,611		5,611			35
36	Other (specify):*							60,238	60,238			36
37	TOTAL Ownership			630,406	630,406	77	630,483	(168,949)	461,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,759	417,239	566,998		566,998		566,998			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,122	229,122		229,122		229,122			42
43	Other (specify):*			9,742	9,742		9,742	(9,742)				43
44	TOTAL Special Cost Centers		149,759	656,103	805,862		805,862	(9,742)	796,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,375,952	402,460	2,789,119	5,567,531		5,567,531	(533,699)	5,033,832			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,451)	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	135,764	30		9
10	Interest and Other Investment Income	(934)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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				18
19	Entertainment				19
20	Contributions	(4,775)	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	(58,689)	21		24
25	Fund Raising, Advertising and Promotional	(573)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(251,670)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,361)		\$	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)	(347,338)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (347,338)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (533,699)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (27,427)	21	1
2	Vending Income	(551)	02	2
3	Misc Income	(381)	02	3
4	Marketing Expense	(9,742)	43	4
5	PAC Dues	(4,157)	20	5
6	Capitalized R&M	(9,018)	06	6
7	Bank Fees	(6,929)	21	7
8	Bldg Co - Professional Fees	(20,827)	19	8
9	Bldg Co - Closing Costs	(60,238)	21	9
10	Bldg Co - Real Estate Taxes	(92,650)	33	10
11	Additional R&M	5,209	06	11
12	Non Allowable Legal Fees	(329)	19	12
13	Non Allowable PY Professional Fees	(24,630)	21	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	(251,670)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(965)		1,130		115							280	2
3	Housekeeping			966									966	3
4	Laundry													4
5	Heat and Other Utilities	(5,451)		672									(4,779)	5
6	Maintenance	(3,809)		3,039		30							(740)	6
7	Other (specify):*													7
8	TOTAL General Services	(10,225)		5,807		145							(4,273)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(6,120)							(6,120)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,048							7,048	15
16	TOTAL Health Care and Programs					928							928	16
	C. General Administration													
17	Administrative			(161,913)			(124,749)						(286,662)	17
18	Directors Fees													18
19	Professional Services	(21,156)	20,827	784	207	3,695	177						4,534	19
20	Fees, Subscriptions & Promotions	(9,505)		1,207	16	24							(8,258)	20
21	Clerical & General Office Expenses	(177,913)		79,569		10,963							(87,381)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			367		450							817	24
25	Other Admin. Staff Transportation					2,955							2,955	25
26	Insurance-Prop.Liab.Malpractice			601			4,251						4,852	26
27	Other (specify):*			16,571		908							17,479	27
28	TOTAL General Administration	(208,574)	20,827	(62,814)	223	18,995	(120,321)						(351,664)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(218,799)	20,827	(57,007)	223	20,068	(120,321)						(355,009)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	135,764		1,308	1,749								138,820	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(934)	146,199		1,187								146,452	32
33	Real Estate Taxes	(92,650)	86,671		2,554								(3,425)	33
34	Rent-Facility & Grounds		(515,333)	9,407	(5,108)								(511,034)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		60,238										60,238	36
37	TOTAL Ownership	42,180	(222,225)	10,715	382								(168,949)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,742)											(9,742)	43
44	TOTAL Special Cost Centers	(9,742)											(9,742)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(186,361)	(201,398)	(46,292)	605	20,068	(120,321)						(533,699)	45

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 PG6Supp		See PG6Supp		See PG6Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 515,333	Rock River Health Care Realty LLC	100.00%	\$	(515,333)	1
2	V	19	Professional Fees		Rock River Health Care Realty LLC	100.00%	20,827	20,827	2
3	V	32	Interest Expense		Rock River Health Care Realty LLC	100.00%	146,199	146,199	3
4	V	36	Closing Costs		Rock River Health Care Realty LLC	100.00%	60,238	60,238	4
5	V	33	Real Estate Taxes		Rock River Health Care Realty LLC	100.00%	86,671	86,671	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			\$ 515,333			\$ 313,935	\$ * (201,398)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 1,130	\$ 1,130	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	966	966	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	672	672	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,039	3,039	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	7,726	7,726	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	7,611	7,611	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	784	784	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,207	1,207	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	4,410	4,410	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	75,160	75,160	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	367	367	25
26	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	601	601	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	16,571	16,571	27
28	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,308	1,308	28
29	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	9,407	9,407	29
30	V								30
31	V	17	MANAGEMENT FEES	177,250	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(177,250)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 177,250			\$ 130,958	\$ * (46,292)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	207	\$	207
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	16		16
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	1,749		1,749
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,187		1,187
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	2,554		2,554
20	V								20
21	V	34	RENT	5,108	PREMIER HC REAL ESTATE, LLC	100.00%			(5,108)
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			\$ 5,108			\$ 5,713	\$ *	605

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 115	\$ 115	15
16	V	6	REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	30	30	16
17	V	10	NURSING SALARIES		iCare Consulting Services LLC	100.00%	67,397	67,397	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	7,048	7,048	18
19	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	3,695	3,695	19
20	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	24	24	20
21	V	21	CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	2,920	2,920	21
22	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	8,401	8,401	22
23	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	450	450	23
24	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	908	908	24
25	V	25	AUTO & TRAVEL		iCare Consulting Services LLC	100.00%	2,955	2,955	25
26	V								26
27	V	10	RN CONSULTANT	73,517	iCare Consulting Services LLC	100.00%		(73,517)	27
28	V	21	COMPUTER EXPENSE	358	iCare Consulting Services LLC	100.00%		(358)	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			\$ 73,875			\$ 93,943	\$ * 20,068	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SALARY	\$	Saba Healthcare	100.00%	\$ 52,501	\$ 52,501	15
16	V	19	PROFESSIONAL FEES		Saba Healthcare	100.00%	177	177	16
17	V	26	INSURANCE		Saba Healthcare	100.00%	4,251	4,251	17
18	V	17	MANAGEMENT FEES	177,250	Saba Healthcare	100.00%		(177,250)	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			\$ 177,250			\$ 56,929	\$ * (120,321)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Shimon Webster	17.50%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO	1
2	Yeruchom Levovitz	14.42%	PARK VIEW REHAB CENTER	CHICAGO	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO	2
3	Moshe Levovitz	1.54%	PINE CREST HEALTH CARE	HAZEL CREST	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING CO	3
4	CTCAAR LLC	1.54%	RIVER VIEW REHAB CENTER	ELGIN	SABA HEALTHCARE	SKOKIE, IL	CONSULTING CO	4
5	Kevin Chankin	2.50%	FOREST CITY REHAB & NURSING	ROCKFORD	ROCK RIVER HC REALTY	ROCKFORD, IL	BUILDING CO	5
6	Aharon Singer	13.25%	PEARL PAVILION	FREEPORT				6
7	Benzion Fishbane	1.00%	BROOK CHATEAU	KANSAS CITY, MO				7
8	Moshe Blonder	13.25%	LEISURE TERRACE	OVERLAND PARK,KS				8
9	ATIED Associates LLC	20.00%	BREEZY MEADOWS	BUTLER, MO				9
10	SMF Healthcare LLC	15.00%						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	17.50%	See Attachment	2.55	6.38%	Alloc Salary	\$ 7,726	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	14.42%	See Attachment	2.55	6.38%	Alloc Salary	7,611	17-7	2
3	Kevin Chankin	Owner	Clerical	2.50%	See Attachment	2.55	6.38%	Alloc Salary	12,770	21-7	3
4	Tzvi Singer	Relative	Administrative	0%	See Attachment	40	100.00%	Alloc Salary	80,205	17-1	4
5	Moshe Blonder	Owner	Administrative	13.25%	See Attachment	5.25	13.13%	Alloc Salary	26,254	17-7	5
6	Aharon Singer	Owner	Administrative	13.25%	See Attachment	5.25	13.13%	Alloc Salary	26,254	17-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 160,820		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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	DIETARY	PATIENT DAYS	441,943	10	\$ 17,705	\$	28,219	\$ 1,130	1
2	3	HOUSEKEEPING	PATIENT DAYS	441,943	10	15,135		28,219	966	2
3	5	UTILITIES	PATIENT DAYS	441,943	10	10,527		28,219	672	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	47,591		28,219	3,039	4
5	17	S WEBSTER SALARY	PATIENT DAYS	441,943	10	120,995	120,995	28,219	7,726	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	441,943	10	119,190	119,190	28,219	7,611	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	12,272		28,219	784	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	18,896		28,219	1,207	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	69,058		28,219	4,410	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	1,177,077	1,177,077	28,219	75,160	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	5,755		28,219	367	11
12	26	INSURANCE	PATIENT DAYS	441,943	10	9,405		28,219	601	12
13	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	259,519		28,219	16,571	13
14	30	DEPRECIATION	PATIENT DAYS	441,943	10	20,479		28,219	1,308	14
15	34	RENT	PATIENT DAYS	441,943	10	147,325		28,219	9,407	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,050,929	\$ 1,417,262		\$ 130,958	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	3,241		28,219	207	1
2	20	LICENSES & PERMITS	PATIENT DAYS	441,943	10	250		28,219	16	2
3	30	DEPRECIATION	PATIENT DAYS	441,943	10	27,389		28,219	1,749	3
4	32	INTEREST EXPENSE	PATIENT DAYS	441,943	10	18,587		28,219	1,187	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	441,943	10	40,000		28,219	2,554	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					\$ 89,467	\$		\$ 5,713	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	441,943	10	\$ 1,804	\$	28,219	\$ 115	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	472		28,219	30	2
3	10	NURSING SALARIES	PATIENT DAYS	441,943	10	1,055,519	1,084,019	28,219	67,397	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	441,943	10	110,378		28,219	7,048	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	57,864		28,219	3,695	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	369		28,219	24	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	45,733		28,219	2,920	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	131,573	131,573	28,219	8,401	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	7,055		28,219	450	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	14,224		28,219	908	10
11	25	AUTO & TRAVEL	PATIENT DAYS	345,177	7	36,142		28,219	2,955	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					\$ 1,461,133	\$ 1,215,592		\$ 93,943	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Saba Healthcare
Street Address 8131 Monticello Ave
City / State / Zip Code Skokie, IL 60076
Phone Number (773) 945-1000
Fax Number (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SALARY	Patient Days	214,996	6	\$ 400,000	\$ 400,000	28,219	\$ 52,501	1
2	19	PROFESSIONAL FEES	Patient Days	214,996	6	1,350		28,219	177	2
3	26	INSURANCE	Patient Days	214,996	6	32,391		28,219	4,251	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					\$ 433,741	\$ 400,000		\$ 56,929	25

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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: 01/01/16 Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	MB Financial		X	Mortgage			\$	4,349,215			\$ 146,199	1	
2												2	
3												3	
4												4	
5					-							5	
	Working Capital												
6	MB Financial		X	Line of Credit							9,186	6	
7	Alloc Premier HC Realty	X									1,187	7	
8					-							8	
9	TOTAL Facility Related						\$	4,349,215				\$ 156,572	9
	B. Non-Facility Related*												
10	Interest Income		X								(934)	10	
11	Interest Income											11	
12												12	
13					-							13	
14	TOTAL Non-Facility Related						\$					\$ (934)	14
15	TOTALS (line 9+line14)						\$	4,349,215				\$ 155,638	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Rock River Health Care

COUNTY

Winnebago

FACILITY IDPH LICENSE NUMBER

0053231

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,200 **B. General Construction Type:** **Exterior** Frame **Number of Stories** 1

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

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

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

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

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

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

None

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

1. Total Amount Incurred:	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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	250,035	2014	\$ 175,000	1
2	Allocated From Premier HC Realty			1,213	2
3	TOTALS	250,035		\$ 176,213	3

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rock River Health Care

0053231

Report Period Beginning:

01/01/16

Ending:

12/31/16

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)								67
68	Related Party Allocations (Pages 12H & 12I)		72,128	2,996		3,031	35	15,139	68
69	Financial Statement Depreciation			7,627			(7,627)		69
70	TOTAL (lines 4 thru 69)		\$ 3,072,128	\$ 10,623		\$ 88,745	\$ 78,122	\$ 272,282	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:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,072,128	\$ 10,623		\$ 88,745	\$ 78,122	\$ 272,282	1
2	Security Camera-16 Channel Nvr- Dome Camera Wall Mount	2015	7,130		20	1,070	1,070	2,139	2
3	Security Camera- Wiring, Jacks, Surface Boxes, Plates	2015	13,405		20	2,011	2,011	4,022	3
4	Replaced Chiller- High Pressure Control	2015	10,959		20	1,096	1,096	2,192	4
5	Asphalt-Garbage Pad & Sidewalks(Front Prmter),Glass & Doors	2015	400,000		20	6,633	6,633	13,267	5
6	Replacement Of Boiler	2015	4,448		20	222	222	445	6
7	Water System Installation, Tap Water Aami Analysis	2016	5,665		20	283	283	283	7
8	Replace Leaking Tubes In Boiler, Re-Line Front Firebox Door	2016	3,800		20	158	158	158	8
9	Boiler Pump Replacement	2016	8,634		20	324	324	324	9
10	Boiler Improvements	2016	4,478		20	187	187	187	10
11	Chiller Work	2016	5,369		20	157	157	157	11
12	2 New Boilers	2016	25,560		20	320	320	320	12
13	Set Up Temporary Carrier Chiller	2016	5,818		20	291	291	291	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)		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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:

01/01/16

Ending:

12/31/16

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		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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)		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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:

01/01/16

Ending:

12/31/16

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		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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:

01/01/16

Ending:

12/31/16

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		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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)		\$ 3,567,394	\$ 10,623		\$ 101,496	\$ 90,873	\$ 296,065	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:

01/01/16

Ending:

12/31/16

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									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)		\$	\$		\$	\$	\$	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:

01/01/16

Ending:

12/31/16

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
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)		\$	\$		\$	\$	\$	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:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Premier Healthcare Realty	2011	23,779	610	39	679	69	3,453	3
4	Premier Healthcare Realty	2012	3,027	78	39	86	8	433	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Premier HealthCare & Financial Services, Inc	2012	540	5	10	27	22	135	9
10	Premier HealthCare & Financial Services, Inc	2016	1,264	1,264	10	63	(1,201)	63	10
11									11
12	Allocated from Premier Healthcare Realty	2011	42,292	1,008	20	2,115	1,107	10,749	12
13	Allocated from Premier Healthcare Realty	2012	1,226	31	20	61	30	306	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)		\$ 72,128	\$ 2,996		\$ 3,031	\$ 35	\$ 15,139	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:

01/01/16

Ending:

12/31/16

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		\$ 72,128	\$ 2,996		\$ 3,031	\$ 35	\$ 15,139	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)		\$ 72,128	\$ 2,996		\$ 3,031	\$ 35	\$ 15,139	34

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

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	\$404,718	\$22	\$44,628	\$44,606	10	\$127,513	71
72	Current Year Purchases	3,226	38	323	285	10	323	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$407,944	\$60	\$44,950	\$44,890		\$127,836	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	2	
	Reference	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)	\$4,151,551	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$10,683	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$146,447	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$135,764	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$423,901	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	CIP	\$25,560	92
93			93
94			94
95		\$25,560	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Premier				4,299			6
7	TOTAL				\$4,299			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:
- *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$5,611
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2017\$
13. /2018\$
14. /2019\$

* 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.

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

☒ 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 197,654	\$		\$ 197,654	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			41,178			41,178	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			172,948			172,948	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				73,045		73,045	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					5,459	76,714		82,173	13
14	TOTAL			\$		\$ 417,239	\$ 149,759		\$ 566,998	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,316	\$ 134,073	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,110,379	1,110,379	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	150,144	150,144	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	27,078	27,078	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,295,917	\$ 1,421,674	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		3,000,000	14
15	Leasehold Improvements, at Historical Cost	29,176	878,391	15
16	Equipment, at Historical Cost	74,077	399,077	16
17	Accumulated Depreciation (book methods)	(54,717)	(336,035)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,546	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,379)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	25,678	526,242	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 74,214	\$ 4,657,842	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,370,131	\$ 6,079,516	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 432,300	\$ 432,300	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,876	1,876	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,919	207,919	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,993	6,993	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	30,195	540,465	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 679,283	\$ 1,269,553	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,349,215	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,349,215	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 679,283	\$ 5,618,768	46
47	TOTAL EQUITY(page 18, line 24)	\$ 690,848	\$ 460,748	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,370,131	\$ 6,079,516	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 682,894	1
2	Restatements (describe):		2
3	Late Journal Entry	(116,850)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 566,044	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,304	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	(32,500)	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)	\$ 124,804	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)	\$ 690,848	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Rock River Health Care**# **0053231**Report Period Beginning: **01/01/16**Ending: **12/31/16**

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,485,913	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,485,913	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,024	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,024	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	934	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 934	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	236,964	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 236,964	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,724,835	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	909,692	31
32	Health Care	1,876,600	32
33	General Administration	1,344,971	33
	B. Capital Expense		
34	Ownership	630,406	34
	C. Ancillary Expense		
35	Special Cost Centers	576,740	35
36	Provider Participation Fee	229,122	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,567,531	40
41	Income before Income Taxes (line 30 minus line 40)**	157,304	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 157,304	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,356,663	44
45	Private Pay - Net Inpatient Revenue	97,785	45
46	Medicare - Net Inpatient Revenue	1,534,674	46
47	Other-(specify) Hospice	393,716	47
48	Other-(specify) Insurance	112,534	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,495,372	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,744	1,957	\$ 72,770	\$ 37.18	1
2	Assistant Director of Nursing	2,006	2,161	53,880	24.93	2
3	Registered Nurses	10,650	11,367	302,703	26.63	3
4	Licensed Practical Nurses	14,891	16,162	404,575	25.03	4
5	CNAs & Orderlies	40,377	43,490	519,063	11.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,225	1,323	13,503	10.21	8
9	Activity Director	1,920	2,121	33,220	15.66	9
10	Activity Assistants	4,714	5,178	73,655	14.22	10
11	Social Service Workers	6,229	6,591	191,601	29.07	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,084	60,727	29.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,103	17,117	182,104	10.64	15
16	Dishwashers					16
17	Maintenance Workers	1,491	1,660	14,688	8.85	17
18	Housekeepers	15,777	17,096	198,659	11.62	18
19	Laundry	2,322	2,548	23,464	9.21	19
20	Administrator	3,220	3,246	131,802	40.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,588	4,769	65,941	13.83	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	1,872	2,055	33,597	16.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,097	140,925	\$ 2,375,952 *	\$ 16.86	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	144	\$ 7,776	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	73,517	10-03	38
39	Pharmacist Consultant	Monthly	4,995	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	30	1,950	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	1,118	55,880	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,292	\$ 151,318		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number

Rock River Health Care

0053231

Report Period Beginning:

01/01/16

Ending:

12/31/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Tzvi Singer (1/1-12/31)

Assnt Admin

0

\$ 80,205

Steve Bennett (09/02-12/31)

Administrator

0

27,543

Heath Schiesher (03/04-04/15)

Administrator

0

10,128

Anthony Valentino (01/01-3/4)

Administrator

0

13,926

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 131,802

B. Administrative - Other

Description

Amount

Management Fees - Premier HC & Financial Services

\$ 177,250

Management Fees - Saba Healthcare

177,250

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 354,500

C. Professional Services

Vendor/Payee

Type

Amount

See Attachment

Legal Services

\$ 419

Marcum, LLP

Accounting Fees

15,000

ML Group Design & Development

Architect/Design Fees

7,425

Graphics and Support

Design Fees

450

Kevin Chankin

Other Professional Fees

57

MTS Consulting

Tax Consulting Fees

2,112

Prospect Resources

Other Professional Fees

600

Assurance Agency

Insurance Consulting

1,000

Chartwell Agency

Event Services

5,000

Creative Technology

Data Processing

8,688

Reliable Health Systems

Data Processing

12,090

See Supplemental Schedule

18,852

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 71,692

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 78,222

Unemployment Compensation Insurance

87,591

FICA Taxes

178,229

Employee Health Insurance

36,489

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Expense

3,483

Christmas Expense

63

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

\$ 384,077

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

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,083

Health Care Worker Background Check

4,134

(Indicate # of checks performed 413)

Patient Background Checks

Dues ICLTC

8,440

License Fees/Dues

3,347

Allocated from iCare Consulting

Allocated from Premier HC & Financial

1,207

See Supplemental Schedule

40

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

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

\$ 19,251

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,071

Allocated from Premier HC & Financial

367

Allocated from iCare Consulting

450

Entertainment Expense

()

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

TOTAL

\$ 1,888

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Rock River Health Care	STATE OF ILLINOIS # 0053231	Report Period Beginning: 01/01/16	Ending: 12/31/16	Page 22
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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. ICLTC \$ 12,597

(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. \$ 10,736 Line 10-02

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 229,122
 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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
 d. Have vehicle usage logs been maintained? No
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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