



Facility Name & ID Number Rock River Health Care

# 0053231 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	140	181	4,463	4,784	8
9	SNF/PED					9
10	ICF	23,126	682	2,241	26,049	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,266	863	6,704	30,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.98%

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/1/2014

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 69 and days of care provided 3,794

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Rock River Health Care # 0053231 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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
	<b>A. General Services</b>										
1	Dietary	236,583	18,685	10,124	265,392		265,392		265,392		1
2	Food Purchase		172,500		172,500		172,500	(398)	172,102		2
3	Housekeeping	194,483	19,701		214,184		214,184	635	214,819		3
4	Laundry	25,342	10,961		36,303		36,303		36,303		4
5	Heat and Other Utilities			113,049	113,049		113,049	(5,330)	107,719		5
6	Maintenance	18,599	26,208	50,013	94,820		94,820	(9,440)	85,380		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>475,007</b>	<b>248,055</b>	<b>173,186</b>	<b>896,248</b>		<b>896,248</b>	<b>(14,533)</b>	<b>881,715</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,520,859	27,673	77,558	1,626,090		1,626,090	(19,375)	1,606,715		10
10a	Therapy	27,049			27,049		27,049		27,049		10a
11	Activities	102,694	5,444		108,138		108,138		108,138		11
12	Social Services	101,277		5,465	106,742		106,742		106,742		12
13	CNA Training										13
14	Program Transportation			894	894		894		894		14
15	Other (specify):*							6,508	6,508		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,751,879</b>	<b>33,117</b>	<b>91,117</b>	<b>1,876,113</b>		<b>1,876,113</b>	<b>(12,867)</b>	<b>1,863,246</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	140,413		151,690	292,103		292,103	(130,987)	161,116		17
18	Directors Fees										18
19	Professional Services			91,803	91,803		91,803	(28,404)	63,399		19
20	Dues, Fees, Subscriptions & Promotions			27,344	27,344		27,344	(4,311)	23,033		20
21	Clerical & General Office Expenses	52,296		73,331	125,627		125,627	23,998	149,625		21
22	Employee Benefits & Payroll Taxes			349,026	349,026		349,026		349,026		22
23	Inservice Training & Education										23
24	Travel and Seminar			60	60		60	633	693		24
25	Other Admin. Staff Transportation			4,035	4,035		4,035	3,753	7,788		25
26	Insurance-Prop.Liab.Malpractice			145,514	145,514		145,514	519	146,033		26
27	Other (specify):*							13,766	13,766		27
28	<b>TOTAL General Administration</b>	<b>192,709</b>		<b>842,803</b>	<b>1,035,512</b>		<b>1,035,512</b>	<b>(121,033)</b>	<b>914,479</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,419,595</b>	<b>281,172</b>	<b>1,107,106</b>	<b>3,807,873</b>		<b>3,807,873</b>	<b>(148,434)</b>	<b>3,659,439</b>		<b>29</b>

\*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 &amp; ID Number

Rock River Health Care

#0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			42,933	42,933		42,933	101,936	144,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,862	9,862		9,862	307,284	317,146			32
33	Real Estate Taxes			79,800	79,800		79,800	78,890	158,690			33
34	Rent-Facility & Grounds			248,445	248,445		248,445	(248,445)	0			34
35	Rent-Equipment & Vehicles			4,474	4,474		4,474		4,474			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			385,514	385,514		385,514	239,665	625,179			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,321	436,645	583,966		583,966		583,966			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,445	227,445		227,445		227,445			42
43	Other (specify):*			219,632	219,632		219,632	(219,632)				43
44	<b>TOTAL Special Cost Centers</b>		147,321	883,722	1,031,043		1,031,043	(219,632)	811,411			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,419,595	428,493	2,376,342	5,224,430		5,224,430	(128,400)	5,096,030			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:

**01/01/15**

Ending:

**12/31/15**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(5,862)	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	(126,662)	30		9
10	Interest and Other Investment Income	(261)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	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	(878)	21		18
19	Entertainment				19
20	Contributions	(361)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(317,228)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (451,300)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	322,900		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 322,900		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (128,400)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Rock River Health Care

ID# 0053231

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Expense	\$ (12,937)	43	1
2	Sequestration Expense	(38,345)	21	2
3	Vending Income	(1,524)	02	3
4	Bank Charges	(5,927)	21	4
5	Non Allowable Expense	(206,695)	43	5
6	Capitalized R&M	(10,595)	06	6
7				7
8	Bldg. Co - Amortization	(1,103)	36	8
9	Bldg. Co - Professional Fees	(3,445)	19	9
10	Non Allowable Legal	(30,208)	19	10
11	PAC Dues	(6,449)	20	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	<b>Total</b>	(317,228)		49

Rock River Health Care

ID# 0053231  
 Report Period Beginning: 01/01/15  
 Ending: 12/31/15

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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock River Health Care# 0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	(1,572)		1,081		93							(398)	2
3	Housekeeping			635									635	3
4	Laundry													4
5	Heat and Other Utilities	(5,862)		532									(5,330)	5
6	Maintenance	(10,595)		1,129		26							(9,440)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(18,029)</b>		<b>3,377</b>		<b>119</b>							<b>(14,533)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records					(19,375)							(19,375)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,508							6,508	15
16	<b>TOTAL Health Care and Programs</b>					<b>(12,867)</b>							<b>(12,867)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(133,665)		2,678							(130,987)	17
18	Directors Fees													18
19	Professional Services	(33,653)	3,445	541	80	1,183							(28,404)	19
20	Fees, Subscriptions & Promotions	(6,810)		2,465	17	17							(4,311)	20
21	Clerical & General Office Expenses	(45,150)		58,563		10,585							23,998	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			239		394							633	24
25	Other Admin. Staff Transportation			522		3,231							3,753	25
26	Insurance-Prop.Liab.Malpractice			519									519	26
27	Other (specify):*			12,526		1,240							13,766	27
28	<b>TOTAL General Administration</b>	<b>(85,613)</b>	<b>3,445</b>	<b>(58,290)</b>	<b>97</b>	<b>19,328</b>							<b>(121,033)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(103,642)</b>	<b>3,445</b>	<b>(54,913)</b>	<b>97</b>	<b>6,580</b>							<b>(148,434)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock River Health Care# 0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(126,662)	226,091	673	1,833								101,936	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(261)	306,250		1,295								307,284	32
33	Real Estate Taxes		76,218		2,672								78,890	33
34	Rent-Facility & Grounds		(248,445)	6,163	(6,163)								(248,445)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(1,103)	1,103											36
37	<b>TOTAL Ownership</b>	<b>(128,026)</b>	<b>361,217</b>	<b>6,837</b>	<b>(363)</b>								<b>239,665</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(219,632)											(219,632)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(219,632)</b>											<b>(219,632)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(451,300)	364,662	(48,076)	(266)	6,580							(128,400)	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 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.**  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	\$ 248,445	Rock River Health Care Realty LLC	100.00%	\$	\$ (248,445)	1
2	V	19 Professional Fees		Rock River Health Care Realty LLC	100.00%	3,445	3,445	2
3	V	32 Interest Expense		Rock River Health Care Realty LLC	100.00%	306,250	306,250	3
4	V	33 Real Estate Taxes		Rock River Health Care Realty LLC	100.00%	76,218	76,218	4
5	V	36 Amortization - Organization Costs		Rock River Health Care Realty LLC	100.00%	1,103	1,103	5
6	V	30 Depreciation Expense		Rock River Health Care Realty LLC	100.00%	226,091	226,091	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 248,445			\$ 613,107	\$ * 364,662	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						
			\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 1,081	\$	1,081
16	V	3						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	635		635
17	V	5						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	532		532
18	V	6						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,129		1,129
19	V	17						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	9,250		9,250
20	V	17						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8,777		8,777
21	V	19						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	541		541
22	V	20						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,465		2,465
23	V	21						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	6,124		6,124
24	V	21						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	52,439		52,439
25	V	24						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	239		239
26	V	25						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	522		522
27	V	26						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	519		519
28	V	27						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,526		12,526
29	V	30						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	673		673
30	V	34						
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	6,163		6,163
31	V							
32	V	17						
			151,692					(151,692)
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 151,692			\$ 103,616	\$ *	(48,076)

\* 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%	80	\$	80	15
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	17		17	16
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	1,833		1,833	17
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,295		1,295	18
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	2,672		2,672	19
20	V	34 RENT	6,163					(6,163)	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		\$ 6,163			\$ 5,897	\$ *	(266)	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	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 93	\$	93	15
16	V	3 HOUSEKEEPING		iCare Consulting Services LLC	100.00%				16
17	V	5 UTILITIES		iCare Consulting Services LLC	100.00%				17
18	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	26		26	18
19	V	10 NURSING SALARIES	73,839	iCare Consulting Services LLC	100.00%	54,464		(19,375)	19
20	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	6,508		6,508	20
21	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%				21
22	V	17 M LEVOVITZ-SALARY		iCare Consulting Services LLC	100.00%	2,678		2,678	22
23	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	1,183		1,183	23
24	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	17		17	24
25	V	21 CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	2,887		2,887	25
26	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	7,698		7,698	26
27	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	394		394	27
28	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	3,231		3,231	28
29	V	26 INSURANCE		iCare Consulting Services LLC	100.00%				29
30	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,240		1,240	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		\$ 73,839			\$ 80,419	\$ *	6,580	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:

01/01/15

Ending:

12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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:

01/01/15

Ending:

12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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:

01/01/15

Ending:

12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Rock River Health Care

#

0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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 Attached	2.67	6.68%	Alloc. Salary	\$ 9,250	17-7	1	
2	Yeruchom Levovitz	Owner	Administrative	14.42%	See Attached	2.67	6.68%	Alloc. Salary	8,777	17-7	2	
3	Kevin Chankin	Owner	Clerical	2.50%	See Attached	2.67	6.68%	Alloc. Salary	9,650	21-7	3	
4	Moshe Levovitz	Owner	Clerical	1.54%	See Attached	0.67	1.68%	Alloc. Salary	670	21-7	4	
5	Tzvi Singer	Relative	Administrative		See Attached	40.00	100.00%	Salary	50,243	17-1	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	\$ 78,590		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:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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:

01/01/15

Ending: 12/31/15

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 8153 N. LAWNDALE  
 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 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	2	DIETARY	PATIENT DAYS	461,493	11	\$ 16,187	\$ 30,833	\$ 1,081	1	
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11	9,503	30,833	635	2	
3	5	UTILITIES	PATIENT DAYS	461,493	11	7,957	30,833	532	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	16,899	30,833	1,129	4	
5	17	S WEBSTER SALARY	PATIENT DAYS	461,493	11	138,451	138,451	30,833	9,250	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	131,370	131,370	30,833	8,777	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	8,102	30,833	541	7	
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	36,899	30,833	2,465	8	
9	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	91,659	30,833	6,124	9	
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	784,868	784,868	30,833	52,439	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	3,583	30,833	239	11	
12	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	7,819	30,833	522	12	
13	26	INSURANCE	PATIENT DAYS	461,493	11	7,768	30,833	519	13	
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	187,476	30,833	12,526	14	
15	30	DEPRECIATION	PATIENT DAYS	461,493	11	10,078	30,833	673	15	
16	34	RENT	PATIENT DAYS	461,493	11	92,250	30,833	6,163	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,550,868	\$ 1,054,689	\$ 103,616	25	

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 8153 N. LAWNSDALE  
 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 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	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	1,195	30,833	80	1
2	20	LICENSES & PERMITS	PATIENT DAYS	461,493	11	250	30,833	17	2
3	30	DEPRECIATION	PATIENT DAYS	461,493	11	27,440	30,833	1,833	3
4	32	INTEREST EXPENSE	PATIENT DAYS	461,493	11	19,378	30,833	1,295	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	461,493	11	40,000	30,833	2,672	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					\$ 88,263	\$	\$ 5,897	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 8153 N. Lawndale  
 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	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	
Line Reference									
1	2	DIETARY	PATIENT DAYS	461,493	11	\$ 1,393	\$ 30,833	\$ 93	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11		30,833		2
3	5	UTILITIES	PATIENT DAYS	461,493	11		30,833		3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	391	30,833	26	4
5	10	NURSING SALARIES	PATIENT DAYS	461,493	11	815,183	815,183	30,833	54,464
6	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	461,493	11	97,410	30,833	6,508	6
7	17	ADMIN SALARY NON-RELATI	PATIENT DAYS	461,493	11		30,833		7
8	17	M LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	40,090	40,090	30,833	2,678
9	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	17,714	30,833	1,183	9
10	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	250	30,833	17	10
11	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	43,215	30,833	2,887	11
12	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	115,221	115,221	30,833	7,698
13	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	5,896	30,833	394	13
14	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	48,366	30,833	3,231	14
15	26	INSURANCE	PATIENT DAYS	461,493	11		30,833		15
16	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	18,559	30,833	1,240	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,203,688	\$ 970,494	\$ 80,419	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rock River Health Care

# 0053231 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	MB Financial		X	Mortgage			\$	\$ 3,500,000		\$ 306,250	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	MB Financial		X	Line of Credit				315,000		9,862	6								
7	Allocated from Premier HC Realty									1,295	7								
8											8								
9	<b>TOTAL Facility Related</b>						\$	\$ 3,815,000		\$ 317,407	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(261)	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (261)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,815,000		\$ 317,146	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:

01/01/15

Ending:

12/31/15

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>																			
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>																			
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>																			

\* 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.)







**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2014</u>	<u>\$ 175,000</u>	<u>1</u>
2	<u>Allocated from Premier HC Realty</u>			<u>1,269</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 176,269</b>	<b>3</b>

Facility Name & ID Number **Rock River Health Care**

# **0053231**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	130		2014	1977	\$ 3,000,000	\$ 226,091	35	\$ 85,714	\$ (140,377)	\$ 171,429	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rock River Health Care

# 0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		74,150	1,812		3,107	1,295	12,669	68
69			42,933			(42,933)		69
70		\$ 3,074,150	\$ 270,836		\$ 88,821	\$ (182,015)	\$ 184,098	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,074,150	\$ 270,836		\$ 88,821	\$ (182,015)	\$ 184,098	1
2	Interior Design- Reception, Resident Rooms-Halls- Walls/Floors	2015	6,600		20	302	302	302	2
3	Security Camera-16 Channel Nvr- Dome Camera Wall Mount	2015	7,130		20	1,070	1,070	1,070	3
4	Security Camera- Wiring, Jacks, Surface Boxes, Plates	2015	13,405		20	2,011	2,011	2,011	4
5	Replaced Chiller- High Pressure Control	2015	10,959		20	1,096	1,096	1,096	5
6	Asphalt-Garbage Pad & Sidewalks(Front Prmter),Glass & Doors	2015	398,000		20	6,633	6,633	6,633	6
7	Replacement Of Boiler	2015	4,448		20	222	222	222	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	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:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	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)	\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	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:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	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		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	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		\$ 3,514,692	\$ 270,836		\$ 100,156	\$ (170,680)	\$ 195,432	34

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

**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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
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.

**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	24,881	638	35	711	73	2,902	3
4	Premier Healthcare Realty	2012	3,168	81	35	91	10	362	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Premier HealthCare & Financial Services, Inc	2012	565	5	20	28	23	113	9
10									10
11	Allocated from Premier Healthcare Realty	2011	44,253	1,055	20	2,213	1,158	9,035	11
12	Allocated from Premier Healthcare Realty	2012	1,283	33	20	64	31	257	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)		\$ 74,150	\$ 1,812		\$ 3,107	\$ 1,295	\$ 12,669	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 74,150	\$ 1,812		\$ 3,107	\$ 1,295	\$ 12,669	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)	\$ 74,150	\$ 1,812		\$ 3,107	\$ 1,295	\$ 12,669	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	\$ 351,737	\$ 27	\$ 35,966	\$ 35,939	10	\$ 74,480	71
72	Current Year Purchases	53,843	668	8,748	8,080	10	8,748	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 405,580	\$ 695	\$ 44,714	\$ 44,019		\$ 83,228	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)	\$ 4,096,541	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 271,531	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,869	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (126,662)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 278,660	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.

**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?  YES  NO

If NO, see instructions.

		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: \_\_\_\_\_ \*

**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: \$ 4,474 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 Ending	Annual Rent
--	--------------------	-------------

12. 2016 \$ \_\_\_\_\_

13. 2017 \$ \_\_\_\_\_

14. 2018 \$ \_\_\_\_\_

\* 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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			430,573			430,573	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 prescripts				80,516		80,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					6,072	66,805		72,877	13
14	TOTAL			\$		\$ 436,645	\$ 147,321		\$ 583,966	14

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

Facility Name & ID Number **Rock River Health Care**# **0053231**Report Period Beginning: **01/01/15**

Ending:

**12/31/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 8,630	\$ 17,939	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,276,398	1,276,398	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	155,777	155,777	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		13,300	8
9	Other(specify):	107,810	107,810	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,548,615	\$ 1,571,224	10
<b>B. Long-Term Assets</b>				
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	406,600	406,600	15
16	Equipment, at Historical Cost	74,077	399,077	16
17	Accumulated Depreciation (book methods)	(47,091)	(328,409)	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):	14,960	14,960	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 448,546	\$ 3,682,395	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,997,161	\$ 5,253,619	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 461,818	\$ 461,818	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,280	3,280	28
29	Short-Term Notes Payable	315,000	315,000	29
30	Accrued Salaries Payable	159,845	159,845	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,966	6,966	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
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	306,983	328,529	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,253,892	\$ 1,355,438	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attached Schedule	60,375		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 60,375	\$ 3,500,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,314,267	\$ 4,855,438	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 682,894	\$ 398,181	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,997,161	\$ 5,253,619	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity From 2014 (No Cost Report)</b>	<b>236,256</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>236,256</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>611,638</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(165,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>446,638</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>682,894</b>	<b>24</b> *

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

Facility Name & ID Number **Rock River Health Care**# **0053231**Report Period Beginning: **01/01/15**

Ending:

**12/31/15****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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,547,962	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,547,962	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	261	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 261	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	287,845	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 287,845	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,836,068	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	896,248	31
32	Health Care	1,876,113	32
33	General Administration	1,035,512	33
<b>B. Capital Expense</b>			
34	Ownership	385,514	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	803,598	35
36	Provider Participation Fee	227,445	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,224,430	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	611,638	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 611,638	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,187,776	44
45	Private Pay - Net Inpatient Revenue	157,812	45
46	Medicare - Net Inpatient Revenue	1,612,460	46
47	Other-(specify) <b>Hospice</b>	388,656	47
48	Other-(specify) <b>Commercial</b>	201,258	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,547,962	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Rock River Health Care**

# **0053231**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	1,088	1,163	\$ 52,520	\$ 45.16	1
2	Assistant Director of Nursing	3,517	3,712	118,372	31.89	2
3	Registered Nurses	10,145	11,093	387,648	34.95	3
4	Licensed Practical Nurses	14,797	16,488	388,779	23.58	4
5	CNAs & Orderlies	43,453	47,189	558,939	11.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,322	2,575	27,049	10.50	8
9	Activity Director	1,912	2,162	32,222	14.90	9
10	Activity Assistants	4,868	5,453	70,472	12.92	10
11	Social Service Workers	3,136	3,421	101,277	29.60	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,162	53,163	24.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,493	16,551	183,420	11.08	15
16	Dishwashers					16
17	Maintenance Workers	1,674	1,766	18,599	10.53	17
18	Housekeepers	16,096	17,656	194,483	11.02	18
19	Laundry	2,320	2,471	25,342	10.26	19
20	Administrator	3,912	4,118	140,413	34.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,550	4,823	52,296	10.84	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	1,098	1,194	14,601	12.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,397	143,997	\$ 2,419,595 *	\$ 16.80	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	187	\$ 10,124	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	73,839	10-03	38
39	Pharmacist Consultant	Monthly	3,719	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	84	5,465	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	272	\$ 100,347		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





Facility Name & ID Number Rock River Health Care# 0053231

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC \$19,541
- (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. \$ 9,918 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. \$ 227,445  
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. \$ No 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% Ln14  
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.