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|  |  | FOR BHF USE |  |  |  |  |  |
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2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)

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: 0050856

Facility Name: Rochelle Rehab & Health Care Center

Address: 900 North 3rd Street Rochelle 61068  
Number City Zip Code

County: Ogle

Telephone Number: (815) 562-4111 Fax #: (815) 562-9671

HFS ID Number:

Date of Initial License for Current Owners: 10/31/2006

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:  
Name: Larry Templin Telephone Number: (309) 689-5869  
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 1/1/2011 to 12/31/2011 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)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Rochelle Rehab & Health Care Center

# 0050856 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

| 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 <u>N/A</u> |                                    |                             |                              |                                        |          |
|                                                                                                                                                   | 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                                                                                                                                                 | <u>50</u>                          | Skilled (SNF)               | <u>50</u>                    | <u>18,250</u>                          | <u>1</u> |
| 2                                                                                                                                                 |                                    | Skilled Pediatric (SNF/PED) |                              |                                        | <u>2</u> |
| 3                                                                                                                                                 |                                    | Intermediate (ICF)          |                              |                                        | <u>3</u> |
| 4                                                                                                                                                 |                                    | Intermediate/DD             |                              |                                        | <u>4</u> |
| 5                                                                                                                                                 |                                    | Sheltered Care (SC)         |                              |                                        | <u>5</u> |
| 6                                                                                                                                                 |                                    | ICF/DD 16 or Less           |                              |                                        | <u>6</u> |
| 7                                                                                                                                                 | <u>50</u>                          | TOTALS                      | <u>50</u>                    | <u>18,250</u>                          | <u>7</u> |

| 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           | <u>4,725</u>                                                | <u>7,101</u> | <u>2,978</u> | <u>14,804</u> | <u>8</u>  |
| 9                                       | SNF/PED       |                                                             |              |              |               | <u>9</u>  |
| 10                                      | ICF           |                                                             |              |              |               | <u>10</u> |
| 11                                      | ICF/DD        |                                                             |              |              |               | <u>11</u> |
| 12                                      | SC            |                                                             |              |              |               | <u>12</u> |
| 13                                      | DD 16 OR LESS |                                                             |              |              |               | <u>13</u> |
| 14                                      | TOTALS        | <u>4,725</u>                                                | <u>7,101</u> | <u>2,978</u> | <u>14,804</u> | <u>14</u> |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.12%

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 ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/31/2006

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 10/31/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 50 and days of care provided 2,819

Medicare Intermediary National Government Services

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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                          |                         |          | 160,234 | 160,234 |                   | 160,234            | (28,633)     | 131,601        |                  |    | 30 |
| 31 | Amortization of Pre-Op. & Org.        |                         |          |         |         |                   |                    |              |                |                  |    | 31 |
| 32 | Interest                              |                         |          | 85,212  | 85,212  |                   | 85,212             | 20,467       | 105,679        |                  |    | 32 |
| 33 | Real Estate Taxes                     |                         |          | 39,938  | 39,938  |                   | 39,938             | 246          | 40,184         |                  |    | 33 |
| 34 | Rent-Facility & Grounds               |                         |          |         |         |                   |                    |              |                |                  |    | 34 |
| 35 | Rent-Equipment & Vehicles             |                         |          | 6,512   | 6,512   |                   | 6,512              | 436          | 6,948          |                  |    | 35 |
| 36 | Other (specify):*                     |                         |          |         |         |                   |                    |              |                |                  |    | 36 |
| 37 | TOTAL Ownership                       |                         |          | 291,896 | 291,896 |                   | 291,896            | (7,484)      | 284,412        |                  |    | 37 |
|    | Ancillary Expense                     |                         |          |         |         |                   |                    |              |                |                  |    |    |
|    | E. Special Cost Centers               |                         |          |         |         |                   |                    |              |                |                  |    |    |
| 38 | Medically Necessary Transportation    |                         |          |         |         |                   |                    |              |                |                  |    | 38 |
| 39 | Ancillary Service Centers             |                         | 144,935  |         | 144,935 |                   | 144,935            |              | 144,935        |                  |    | 39 |
| 40 | Barber and Beauty Shops               |                         |          |         |         |                   |                    |              |                |                  |    | 40 |
| 41 | Coffee and Gift Shops                 |                         |          |         |         |                   |                    |              |                |                  |    | 41 |
| 42 | Provider Participation Fee            |                         |          | 27,375  | 27,375  |                   | 27,375             |              | 27,375         |                  |    | 42 |
| 43 | Other (specify):* Non-allowable Costs | 31,407                  | 350      | 50,909  | 82,666  |                   | 82,666             | (82,666)     |                |                  |    | 43 |
| 44 | TOTAL Special Cost Centers            | 31,407                  | 145,285  | 78,284  | 254,976 |                   | 254,976            | (82,666)     | 172,310        |                  |    | 44 |
| 45 | GRAND TOTAL COST (                    |                         |          |         |         |                   |                    |              |                |                  |    |    |





























































