

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0050856

Facility Name: Rochelle Rehab Healthcare Cr

Address: 900 North Third St 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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
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 1/1/2020 to 12/31/2020
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid
Preparer

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

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

Facility Name & ID Number Rochelle Rehab Healthcare Cr

0050856 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,255	1,793	972	11,020	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,255	1,793	972	11,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.38%

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

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

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

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

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 902

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number **Rochelle Rehab Healthcare Cr** # **0050856** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	117,052	13,063		130,115		130,115	2,934	133,049			1
2	Food Purchase		80,201		80,201		80,201	(90)	80,111			2
3	Housekeeping	112,608	13,495		126,103		126,103	57	126,160			3
4	Laundry	6,873	8,812		15,685		15,685		15,685			4
5	Heat and Other Utilities			49,311	49,311		49,311	200	49,511			5
6	Maintenance	32,569	7,405	19,517	59,491		59,491	1,762	61,253			6
7	Other (specify):*											7
8	TOTAL General Services	269,102	122,976	68,828	460,906		460,906	4,863	465,769			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	632,908	47,223	251,975	932,106		932,106	3,796	935,902			10
10a	Therapy			141,939	141,939		141,939		141,939			10a
11	Activities	15,118	613	(650)	15,081		15,081	597	15,678			11
12	Social Services	34,345			34,345		34,345		34,345			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	682,371	47,836	411,264	1,141,471		1,141,471	4,393	1,145,864			16
	C. General Administration											
17	Administrative	69,504		110,500	180,004		180,004	(94,182)	85,822			17
18	Directors Fees											18
19	Professional Services			6,966	6,966		6,966	10,953	17,919			19
20	Dues, Fees, Subscriptions & Promotions			4,212	4,212		4,212	1,352	5,564			20
21	Clerical & General Office Expenses	24,906	1,520	5,980	32,406		32,406	18,189	50,595			21
22	Employee Benefits & Payroll Taxes			118,769	118,769		118,769	4,995	123,764			22
23	Inservice Training & Education							30	30			23
24	Travel and Seminar							9	9			24
25	Other Admin. Staff Transportation			3,071	3,071		3,071	2,102	5,173			25
26	Insurance-Prop.Liab.Malpractice			32,118	32,118		32,118	320	32,438			26
27	Other (specify):*											27
28	TOTAL General Administration	94,410	1,520	281,616	377,546		377,546	(56,232)	321,314			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,045,883	172,332	761,708	1,979,923		1,979,923	(46,976)	1,932,947			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			109,772	109,772		109,772	(12,399)	97,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							145	145			32
33	Real Estate Taxes			42,759	42,759		42,759	116	42,875			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,033	19,033		19,033	1,065	20,098			35
36	Other (specify):*											36
37	TOTAL Ownership			171,564	171,564		171,564	(11,073)	160,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,235		13,235		13,235		13,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,157	88,157		88,157		88,157			42
43	Other (specify):*	40,710	1,130	47,514	89,354		89,354	(89,354)				43
44	TOTAL Special Cost Centers	40,710	14,365	135,671	190,746		190,746	(89,354)	101,392			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,086,593	186,697	1,068,943	2,342,233		2,342,233	(147,403)	2,194,830			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(90)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,046)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,369)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	43		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	(27,632)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,355)	43		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	(35,310)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,815)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,588)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,588)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (147,403)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ 9,632	43	1
2	X-Rays-Part A	(3,489)	43	2
3	Offset Marketing Salaries	(40,710)	43	3
4	Offset Miscellaneous Nursing Supplies Revenue	(1,444)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(5)	21	5
6	Disallowed Special Events	259	43	6
7	Offset Transportation Revenue	597	11	7
8	Disallowed Chamber of Commerce Dues	(150)	20	8
9				9
10				10
11				11
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,310)		49

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.

[illegible]

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	1	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 2,934	\$ 2,934	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	0		2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	57	57	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	200	200	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,762	1,762	5
6	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	0		6
7	V	9	<u>Medical Director</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	0		7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,749	2,749	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	0		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	0		10
11	V	17	<u>Administrative</u>	110,500	<u>Petersen Health Care Management, Inc.</u>	100.00%	16,318	(94,182)	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	9,639	9,639	12
13	V								13
14	Total			\$ 110,500			\$ 33,659	\$ * (76,841)	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	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 1,502	\$ 1,502	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	18,194	18,194	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	4,995	4,995	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	30	30	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	9	9	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,102	2,102	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	320	320	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	2,970	2,970	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	145	145	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	116	116	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,065	1,065	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			\$			\$ 31,448	\$ * 31,448	39

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

Facility Name & ID Number Rochelle Rehab Healthcare Cr# 0050856Report Period Beginning: 1/1/2020Ending: 12/31/2020

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	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$	\$
16	V	2 Food		Petersen Health Network, LLC	100.00%		
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%		
18	V	5 Utilities		Petersen Health Network, LLC	100.00%		
19	V	6 Maintenance		Petersen Health Network, LLC	100.00%		
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%		
21	V	9 Medical Director		Petersen Health Network, LLC	100.00%		
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	2,491	2,491
23	V	10A Therapy		Petersen Health Network, LLC	100.00%		
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%		
25	V	17 Administrative		Petersen Health Network, LLC	100.00%		
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%		
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	1,314	1,314
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%		
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%		
30	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%		
31	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%		
32	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%		
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%		
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%		
35	V	31 Amortization		Petersen Health Network, LLC	100.00%		
36	V	32 Interest		Petersen Health Network, LLC	100.00%		
37	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%		
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%		
39	Total		\$			\$ 3,805	\$ * 3,805

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

Facility Name & ID Number

Rochelle Rehab Healthcare Cr

0050856

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Rochelle Rehab Healthcare Cr

0050856

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Rochelle Rehab Healthcare Cr

0050856

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rochelle Rehab Healthcare Cr # 0050856 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Rochelle Rehab Healthcare Cr# 0050856

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 341,562	\$ 398,718	11,020	\$ 2,934	1
2	2	Food	Resident Days	75	0	0	11,020	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	11,020	57	3
4	5	Utilities	Resident Days	75	23,320	0	11,020	200	4
5	6	Maintenance	Resident Days	75	205,132	187,746	11,020	1,762	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	11,020	0	6
7	9	Medical Director	Resident Days	75	0	0	11,020	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	11,020	2,749	8
9	10A	Therapy	Resident Days	75	0	0	11,020	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	11,020	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	11,020	16,318	11
12	19	Professional Services	Resident Days	75	1,122,028	0	11,020	9,639	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	11,020	1,502	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	11,020	18,194	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	11,020	4,995	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	11,020	30	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	11,020	9	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	11,020	2,102	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	11,020	320	19
20	30	Depreciation	Resident Days	75	345,756	0	11,020	2,970	20
21	31	Amortization	Resident Days	75	0	0	11,020	0	21
22	32	Interest	Resident Days	75	16,842	0	11,020	145	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	11,020	116	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	11,020	1,065	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 65,107	25

Facility Name & ID Number Rochelle Rehab Healthcare Cr# 0050856

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Petersen Health Network, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	71,843	7	\$	\$	11,020	\$	1
2	2	Food	Resident Days	71,843	7			11,020		2
3	3	Housekeeping	Resident Days	71,843	7			11,020		3
4	5	Utilities	Resident Days	71,843	7			11,020		4
5	6	Maintenance	Resident Days	71,843	7			11,020		5
6	7	Mgmt. Allocation of Benefits	Resident Days	71,843	7			11,020		6
7	9	Medical Director	Resident Days	71,843	7			11,020		7
8	10	Nursing and Medical Records	Resident Days	71,843	7	16,242		11,020	2,491	8
9	10A	Therapy	Resident Days	71,843	7			11,020		9
10	15	Mgmt. Allocation of Benefits	Resident Days	71,843	7			11,020		10
11	17	Administrative	Resident Days	71,843	7			11,020		11
12	19	Professional Services	Resident Days	71,843	7	8,567		11,020	1,314	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	71,843	7			11,020		13
14	21	Clerical and General Office	Resident Days	71,843	7			11,020		14
15	22	Employee Benefits and Payroll Ta	Resident Days	71,843	7			11,020		15
16	23	Inservice Training & Education	Resident Days	71,843	7			11,020		16
17	24	Travel and Seminar	Resident Days	71,843	7			11,020		17
18	25	Other Admin. Staff Transport.	Resident Days	71,843	7			11,020		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	71,843	7			11,020		19
20	30	Depreciation	Resident Days	71,843	7			11,020		20
21	31	Amortization	Resident Days	71,843	7			11,020		21
22	32	Interest	Resident Days	71,843	7			11,020		22
23	33	Real Estate Taxes	Resident Days	71,843	7			11,020		23
24	35	Rent-Equipment & Vehicles	Resident Days	71,843	7			11,020		24
25	TOTALS					\$ 24,809	\$		\$ 3,805	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	9	
	B. Non-Facility Related*													
10													10	
11													11	
12								Home Office Allocation-PHCM				145	12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	145	14
15	TOTALS (line 9+line14)						\$		\$			\$	145	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rochelle Rehab & Health Care Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0050856

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-24-179-007</u>	<u>Long-Term Care Facility</u>	\$ <u>41,715.42</u>	\$ <u>41,715.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>41,715.42</u></u>	\$ <u><u>41,715.42</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

A. Square Feet: 14,800

B. General Construction Type: Exterior BrickFrame Concrete Block

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	105,000	2006	\$ 60,000	1
2					2
3	TOTALS	105,000		\$ 60,000	3

Facility Name & ID Number Rochelle Rehab Healthcare Cr

0050856

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50		2006		\$ 2,182,000	\$	30	\$ 72,733	\$ 72,733	\$ 1,054,629	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel Shower			2007	35,270		15	2,351	2,351	31,739	9
10	Carpeting			2007	9,122		10			9,122	10
11	Exterior Sign			2007	4,130		15	275	275	3,713	11
12	Painting of 10 Rooms			2007	6,175		15	412	412	5,562	12
13	Wallpaper In Living Room, Dining Room, TV Room			2007	3,638		15	243	243	3,280	13
14	Fire Alarm Panel Replacement			2010	3,315		7			3,315	14
15	Sprinkler System Replacement			2011	64,950		15	4,330	4,330	36,805	15
16	Water softener			2013	5,052		7	722	722	4,693	16
17	Flooring and New Shower Install-South Shower Room			2014	3,812		7	545	545	3,543	17
18	Glass Door Install, Flooring, Drywall Remodel-Dining Room			2014	18,511		15	1,234	1,234	8,021	18
19	Gas Pipe Repairs			2014	6,450		7	922	922	4,610	19
20	Roof Replacement			2015	27,420		25	1,098	1,098	5,490	20
21	Roof Repair			2015	2,836		7	406	406	1,827	21
22	Tile Flooring in 2 Showers, 8 Bathrooms and Resident Rooms			2016	27,440		15	1,830	1,830	8,235	22
23	Plaster Repair in Kitchen, Tile Repair in Shower Room			2016	3,112		15	208	208	936	23
24	Air Conditioner Replacement in Adminstrative Office			2016	7,250		15	484	484	2,178	24
25	Shower Room Installation			2017	2,922		10	292	292	1,022	25
26	Flooring in Front Entrance			2017	4,894		10	490	490	1,715	26
27	Shower Room Installation			2018	4,268		15	142	142	426	27
28	Boiler			2019	14,100		15	940	940	1,410	28
29	Boiler Installation Completion of 2019 Work			2020	14,100		15	470	470	470	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 Rochelle Rehab Healthcare Cr

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1/1/2020

Ending:

12/31/2020

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	Building Booked		87,280			(87,280)		58
59	Building Improvement Booked		16,422			(16,422)		59
60								60
61	2020-Home Office Allocation-Building Improvements	5,572			134	134		61
62	2020-Home Office Allocation-Land Improvements	559			35	35		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,456,898	\$ 103,702		\$ 90,296	\$ (13,406)	\$ 1,192,741	70

**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	\$ 31,971	\$ 3,908	\$ 3,195	\$ (713)	5-10 yrs.	\$ 22,387	71
72	Current Year Purchases	3,753	536	268	(268)	7 yrs.	268	72
73	Fully Depreciated Assets	424,128					424,128	73
74	Home Office Allocation			2,801	2,801			74
75	TOTALS	\$ 459,852	\$ 4,444	\$ 6,264	\$ 1,820		\$ 446,783	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	Facility	2007 Ford Econoline Van	2007	\$ 28,738	\$	\$	\$		\$ 28,738
77	Facility	2011 Ford E-350 Van	2019	8,131	1,626	813	(271)	5	1,626
78									
79									
80	TOTALS			\$ 36,869	\$ 1,626	\$ 813	\$ (271)		\$ 30,364

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,013,619
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	109,772
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	97,373
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(11,857)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,669,888

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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?
16. Rental Amount for movable equipment: \$20,098 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☒ YES☐ NO

C. Vehicle Rental (See instructions.)

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

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

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

Rochelle Rehab Healthcare Cr
0050856

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	13,786
Dishwasher		701
Copier		4,546
Home Office Allocation		1,065
		<u>20,098</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,709	\$ 55,633	\$	3,709	\$ 55,633	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,287	19,302		1,287	19,302	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,467	67,004		4,467	67,004	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				13,235		13,235	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,463	\$ 141,939	\$ 13,235	9,463	\$ 155,174	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 309,545	\$ 309,545	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,804)	1,400,930	1,400,930	3
4	Supply Inventory (priced at Cost)	6,814	6,814	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,716	17,716	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	435	435	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,735,440	\$ 1,735,440	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,000	60,000	13
14	Buildings, at Historical Cost	2,182,000	2,187,572	14
15	Leasehold Improvements, at Historical Cost	286,788	269,326	15
16	Equipment, at Historical Cost	496,721	496,721	16
17	Accumulated Depreciation (book methods)	(1,861,583)	(1,669,888)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	23,659	23,659	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,217,585	\$ 1,367,390	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,953,025	\$ 3,102,830	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 422,170	\$ 422,170	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,346	48,346	30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,972	42,972	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	55,357	55,357	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 568,845	\$ 568,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Loan Payable-MCAD Adv. Payment	300,000	300,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 300,000	\$ 300,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 868,845	\$ 868,845	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,084,180	\$ 2,233,985	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,953,025	\$ 3,102,830	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,935,923	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(484,628)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,451,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	632,885	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 632,885	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,084,180	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rochelle Rehab Healthcare Cr

0050856

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,216,960	1
2	Discounts and Allowances for all Levels	(299,164)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,917,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	274,289	6
7	Oxygen	(4,727)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 269,562	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	90	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,338	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,764	20
21	Other Medical Services	(3,965)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,227	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(597)	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	765,130	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 764,533	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,975,118	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	460,906	31
32	Health Care	1,141,471	32
33	General Administration	377,546	33
	B. Capital Expense		
34	Ownership	171,564	34
	C. Ancillary Expense		
35	Special Cost Centers	102,589	35
36	Provider Participation Fee	88,157	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,342,233	40
41	Income before Income Taxes (line 30 minus line 40)**	632,885	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 632,885	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,292,748	44
45	Private Pay - Net Inpatient Revenue	332,395	45
46	Medicare - Net Inpatient Revenue	273,030	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	19,623	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,917,796	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,394	1,521	\$ 46,490	\$ 30.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,461	1,461	47,076	32.22	3
4	Licensed Practical Nurses	2,886	2,969	89,681	30.21	4
5	CNAs & Orderlies	22,356	22,867	380,195	16.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	848	848	13,112	15.46	9
10	Activity Assistants	202	202	2,006	9.93	10
11	Social Service Workers	2,080	2,080	34,345	16.51	11
12	Dietician					12
13	Food Service Supervisor	1,584	1,584	28,066	17.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,307	7,390	88,986	12.04	15
16	Dishwashers					16
17	Maintenance Workers	2,371	2,380	32,569	13.68	17
18	Housekeepers	8,348	8,506	112,608	13.24	18
19	Laundry	750	751	6,873	9.15	19
20	Administrator	2,048	2,080	69,504	33.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,200	1,333	24,906	18.68	23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,775	3,824	110,176	28.81	33
34	TOTAL (lines 1 - 33)	58,610	59,796	\$ 1,086,593 *	\$ 18.17	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	\$		35
36	Medical Director	Monthly 18,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,340	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	14 832	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) Telehealth	4 259	L10, C3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	18 \$ 22,431		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,261 \$ 171,219	L10,C3	50
51	Licensed Practical Nurses	2,433 68,099	L10,C3	51
52	Certified Nurse Assistants/Aides	473 8,226	L10,C3	52
53	TOTAL (lines 50 - 52)	8,167 \$ 247,544		53

Rochelle Rehab Healthcare Cr
0050856
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		1,978	1,978	35.12
Marketing		1,797	1,846	22.05
	TOTAL	3,775	3,824	110,176

**Rochelle Rehab Healthcare Cr
0050856**

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,966

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	170
Duane Morris	Legal	487
Lexis Nexis	Legal	5
Livingston, Barger, Brant, Schroeder	Legal	9
Miller, Hall, Triggs	Legal	29
Miscellaneous	Legal	11
SB2	Legal	88
SmithAmundsen LLC	Legal	542
Sorling Northrup	Legal	155
Illinois Secretary of State	Legal	304
CliftonLarsonAllen	Accounting	674
Ginoli & Co.	Accounting	1,242
Ability Network	Computer Services	1,730
Allscripts	Computer Services	273
AOD Matrix Care	Computer Services	3,038
AT&T	Computer Services	3
ATS	Computer Services	166
CCH	Computer Services	10
Charter Communications	Computer Services	15
Citrix Systems	Computer Services	52
Comcast	Computer Services	18
ITSavvy	Computer Services	80
Kemper Technology	Computer Services	395
Miscellaneous	Computer Services	77
Pearl Technology	Computer Services	72
Stratus Networks	Computer Services	314
TR Professional	Computer Services	7
David Budde	Other Prof Fees	7
DJ Howard and Associates	Other Prof Fees	13
Getzler Henrich & Associates	Other Prof Fees	53
LRI Consulting Services	Other Prof Fees	52
McQuellon Consulting	Other Prof Fees	33
Miscellaneous	Other Prof Fees	58
Optimizer	Other Prof Fees	28
Registered Agent Solutions	Other Prof Fees	16
RSM McGladrey	Other Prof Fees	172
SB2	Other Prof Fees	219
Sedgwick CMS	Other Prof Fees	295
Tarver Program Consultants	Other Prof Fees	41

Total (agree to Schedule V, line 19, column 8)	<u>17,919</u>
--	---------------

Rochelle Rehab Healthcare Cr
0050856
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,062
Auto Repairs		136
Mileage-Travel		1,873
Home Office Allocation		<u>2,102</u>
		<u>5,173</u>

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

No
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (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?
What was the average life used for new equipment added during this period?

Yes

7 yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

11,701

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

88,157

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.

\$

0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

90
- (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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

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.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Ginoli and Company
- (18)

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

Yes
- (19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

No

Attach invoices and a summary of services for all architect and appraisal fees.