

		FOR BHF USE					

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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: 0050849

Facility Name: Roseville Rehab Health Care

Address: 145 S Chamberlain St Roseville 61473
Number City Zip Code

County: Warren

Telephone Number: (309) 426-2134 Fax # (309) 426-2445

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2010

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 Roseville Rehab Health Care

0050849 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	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</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>99</u>	TOTALS	<u>99</u>	<u>36,135</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>12,469</u>	<u>4,602</u>	<u>1,235</u>	<u>18,306</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>12,469</u>	<u>4,602</u>	<u>1,235</u>	<u>18,306</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.66%

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 4/1/2010

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 4/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 1,207

Medicare Intermediary Palmetto

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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 Roseville Rehab Health Care # 0050849 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	152,446	12,454		164,900		164,900	4,874	169,774			1
2	Food Purchase		131,004		131,004		131,004	(5,133)	125,871			2
3	Housekeeping	117,703	15,422		133,125		133,125	94	133,219			3
4	Laundry	41,254	10,911		52,165		52,165		52,165			4
5	Heat and Other Utilities			71,424	71,424		71,424	333	71,757			5
6	Maintenance	47,530	7,482	19,922	74,934		74,934	(4,564)	70,370			6
7	Other (specify):*											7
8	TOTAL General Services	358,933	177,273	91,346	627,552		627,552	(4,396)	623,156			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	909,871	61,747	170,573	1,142,191		1,142,191	4,567	1,146,758			10
10a	Therapy			179,021	179,021		179,021		179,021			10a
11	Activities	44,017	331		44,348		44,348	(3,042)	41,306			11
12	Social Services	27,870	10		27,880		27,880		27,880			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	981,758	62,088	361,594	1,405,440		1,405,440	1,525	1,406,965			16
	C. General Administration											
17	Administrative	60,000		175,100	235,100		235,100	(147,992)	87,108			17
18	Directors Fees											18
19	Professional Services			31,989	31,989		31,989	(3,988)	28,001			19
20	Dues, Fees, Subscriptions & Promotions			1,741	1,741		1,741	2,495	4,236			20
21	Clerical & General Office Expenses	31,007	2,405	10,232	43,644		43,644	29,954	73,598			21
22	Employee Benefits & Payroll Taxes			150,922	150,922		150,922	8,297	159,219			22
23	Inservice Training & Education							50	50			23
24	Travel and Seminar			20	20		20	16	36			24
25	Other Admin. Staff Transportation			6,585	6,585		6,585	3,492	10,077			25
26	Insurance-Prop.Liab.Malpractice			2,160	2,160		2,160	53,902	56,062			26
27	Other (specify):*											27
28	TOTAL General Administration	91,007	2,405	378,749	472,161		472,161	(53,774)	418,387			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,431,698	241,766	831,689	2,505,153		2,505,153	(56,645)	2,448,508			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			11,980	11,980		11,980	194,776	206,756			30
31	Amortization of Pre-Op. & Org.							993	993			31
32	Interest			224	224		224	95,102	95,326			32
33	Real Estate Taxes							119,371	119,371			33
34	Rent-Facility & Grounds			456,738	456,738		456,738	(456,738)				34
35	Rent-Equipment & Vehicles			10,587	10,587		10,587	1,770	12,357			35
36	Other (specify):*											36
37	TOTAL Ownership			479,529	479,529		479,529	(44,726)	434,803			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,326		22,326		22,326		22,326			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,210	157,210		157,210		157,210			42
43	Other (specify):*	18,655	170	78,189	97,014		97,014	(97,014)				43
44	TOTAL Special Cost Centers	18,655	22,496	235,399	276,550		276,550	(97,014)	179,536			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,450,353	264,262	1,546,617	3,261,232		3,261,232	(198,385)	3,062,847			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	(5,133)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,318)	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	59,852	30		9
10	Interest and Other Investment Income	(70)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(339)	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	(58,918)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(620)	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	(38,531)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,077)		\$	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)	(124,308)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (124,308)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (198,385)		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	\$ (6,418)	43	1
2	X-Rays-Part A	(1,358)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(269)	21	3
4	Offset Transportation Revenue	(3,042)	11	4
5	Special Events	(402)	43	5
6	Offset Repairs Insurance Reimb. Revenue	(7,491)	6	6
7	Disallowed Marketing Expense	(18,655)	43	7
8	Pet Expense	(619)	43	8
9	Resident Flowers	(277)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(38,531)		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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,874	\$ 4,874	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	94	94	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	333	333	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,927	2,927	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	4,567	4,567	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	175,100	Petersen Health Care Management, Inc.	100.00%	27,108	(147,992)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	16,012	16,012	12
13	V								13
14	Total			\$ 175,100			\$ 55,915	\$ * (119,185)	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	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,495	\$ 2,495	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	30,223	30,223	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	8,297	8,297	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	50	50	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	16	16	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,492	3,492	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	532	532	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,934	4,934	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	240	240	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	192	192	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,770	1,770	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			\$			\$ 52,241	\$ * 52,241	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	6	Maintenance	\$	Petersen Health Care-Roseville LLC	100.00%	\$	\$	15
16	V	21	Equipment	\$	Petersen Health Care-Roseville LLC	100.00%			16
17	V	26	Insurance-Property		Petersen Health Care-Roseville LLC	100.00%	7,836	7,836	17
18	V	26	Liability Insurance		Petersen Health Care-Roseville LLC	100.00%	32,831	32,831	18
19	V	26	Mortgage Insurance		Petersen Health Care-Roseville LLC	100.00%	12,703	12,703	19
20	V	30	Depreciation		Petersen Health Care-Roseville LLC	100.00%	129,990	129,990	20
21	V	31	Amortization		Petersen Health Care-Roseville LLC	100.00%	993	993	21
22	V	32	Interest	340	Petersen Health Care-Roseville LLC	100.00%	95,272	94,932	22
23	V	33	Real Estate Taxes		Petersen Health Care-Roseville LLC	100.00%	119,179	119,179	23
24	V	34	Rent-Facility & Grounds	456,738	Petersen Health Care-Roseville LLC	100.00%		(456,738)	24
25	V	43	Service Charges		Petersen Health Care-Roseville LLC	100.00%	910	910	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			\$ 457,078			\$ 399,714	\$ * (57,364)	39

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

Facility Name & ID Number

Roseville Rehab Health Care

0050849

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

Roseville Rehab Health Care

0050849

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

Roseville Rehab Health Care

0050849

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

Facility Name & ID Number

Roseville Rehab Health Care

0050849

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			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 Roseville Rehab Health Care # 0050849 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 Roseville Rehab Health Care# 0050849

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 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	1,282,791	75	\$ 341,562	\$ 398,718	18,306	\$ 4,874	1
2	2	Food	Resident Days	1,282,791	75	0	0	18,306	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	18,306	94	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	18,306	333	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	18,306	2,927	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	18,306	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	18,306	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	18,306	4,567	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	18,306	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	18,306	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	18,306	27,108	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	18,306	16,012	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	18,306	2,495	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	18,306	30,223	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	18,306	8,297	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	18,306	50	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	18,306	16	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	18,306	3,492	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	18,306	532	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	18,306	4,934	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	18,306	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	18,306	240	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	18,306	192	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	18,306	1,770	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 108,156	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	Berkadia		X	Mortgage	\$44,073.00	4/1/10	\$ 3,998,669	\$ 2,458,775	3/31/39	0.0614	\$ 95,496	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$44,073.00		\$ 3,998,669	\$ 2,458,775			\$ 95,496	9
	B. Non-Facility Related*											
10								Interest Income Offset			(410)	10
11								Home Office Allocation-PHCM			240	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (170)	14
15	TOTALS (line 9+line14)						\$ 3,998,669	\$ 2,458,775			\$ 95,326	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,703 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	121,980	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	118,795	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,185)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	122,364	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				192	
TOTAL REFUND \$ <u> </u> For <u> </u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	119,371	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	<u> </u>	122,043	8	
	2016	<u> </u>	119,891	9	
	2017	<u> </u>	118,245	10	
	2018	<u> </u>	118,425	11	
	2019	<u> </u>	118,795	12	
Accrual based on prior year tax bill.					

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Roseville Rehabilitation & Health Care COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0050849

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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>07-050-089-10</u>	<u>Land</u>	\$ <u>514.44</u>	\$ <u>514.44</u>
2. <u>07-050-090-00</u>	<u>Nursing Facility</u>	\$ <u>57.38</u>	\$ <u>57.38</u>
3. <u>07-050-107-00</u>	<u>Land</u>	\$ <u>118,223.18</u>	\$ <u>118,223.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>118,795.00</u></u>	\$ <u><u>118,795.00</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,817

B. General Construction Type: Exterior BrickFrame 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: 21,685

2. Number of Years Over Which it is Being Amortized: 21

3. Current Period Amortization: 993

4. Dates Incurred: 2013

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		2010	\$ 400,000	1
2					2
3	TOTALS			\$ 400,000	3

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	99		2010		\$ 2,998,669	\$	25	\$ 119,947	\$ 119,947	\$ 1,139,496
5										
6										
7										
8										
	Improvement Type**									
9	Water Heater			2013	5,776		7	822	822	5,343
10	Carpeting for Activity Room and Main Hallway			2013	10,088		15	672	672	4,368
11	Water Heater			2014	3,228		7	461	461	2,612
12	Shower Room Installation			2016	17,484		15	1,166	1,166	5,247
13	Boiler			2017	18,608		15	1,240	1,240	4,340
14	Removal of Trees			2017	2,650		7	378	378	1,323
15	Water Line Repair			2018	28,298		7	4,042	4,042	10,105
16	Water Heater Replacement			2019	25,495		7	3,642	3,642	5,463
17	Water Softener System			2019	8,178		7	1,168	1,168	1,752
18	Mixing Valve Station			2020	3,257		7	233	233	233
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31	Building Booked					119,947			(119,947)	
32	Building Improvement Booked					14,246			(14,246)	
33										
34	2020-Home Office Allocation-Building Improvements				9,256			222	222	
35	2020-Home Office Allocation-Land Improvements				928			59	59	
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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,131,915	\$ 134,193		\$ 134,052	\$ (141)	\$ 1,180,282	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	\$665,293	\$7,777	\$68,051	\$60,274	5-10 yrs.	\$600,716	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,653	4,653			74
75	TOTALS	\$665,293	\$7,777	\$72,704	\$64,927		\$600,716	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	Van	2012	\$38,000	\$	\$	\$		\$38,000	76
77	Facility	Ford E250	2014	41,349					41,349	77
78										78
79										79
80	TOTALS			\$79,349	\$	\$	\$		\$79,349	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)	\$4,276,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$141,970	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$206,756	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$64,786	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,860,347	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	N/A				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?
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? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 12,357 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Roseville Rehab Health Care
0050849

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	\$	6,993
Copier		3,594
Home Office Allocation		1,770
		<u>12,357</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.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	\$	5,903	\$ 88,550	\$	5,903	\$ 88,550	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,550	23,255		1,550	23,255	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,481	67,216		4,481	67,216	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				22,326		22,326	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			\$	11,934	\$ 179,021	\$ 22,326	11,934	\$ 201,347	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	\$ 1,014,445	\$ 1,014,645	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 67,254)	2,203,895	2,203,895	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,621	23,259	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,234,961	\$ 3,241,799	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		3,007,925	14
15	Leasehold Improvements, at Historical Cost	58,671	123,990	15
16	Equipment, at Historical Cost	122,769	744,642	16
17	Accumulated Depreciation (book methods)	(125,354)	(1,860,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	89	21,685	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,675)	20
21	Restricted Funds		1,116,926	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,175	\$ 3,544,146	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,291,136	\$ 6,785,945	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 566,319	\$ 591,884	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,126	50,126	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		122,364	32
33	Accrued Interest Payable		7,684	33
34	Deferred Compensation	540,973	540,973	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	82,403	82,403	36
37	<u>Accrued Management Fees</u>	2,293,143	2,293,143	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,532,964	\$ 3,688,577	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,458,775	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	532,272	532,272	43
44	<u>Loan Payable-MCAD Adv. Payment</u>	300,000	300,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 832,272	\$ 3,291,047	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,365,236	\$ 6,979,624	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,074,100)	\$ (193,679)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,291,136	\$ 6,785,945	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,133,565)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(84,959)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,218,524)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,144,424	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,144,424	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)	\$ (1,074,100)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Roseville Rehab Health Care

0050849

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	\$ 3,627,200	1
2	Discounts and Allowances for all Levels	(562,260)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,064,940	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	352,713	6
7	Oxygen	2,417	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 355,130	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	5,133	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,318	20
21	Other Medical Services	12,416	21
22	Laundry	3,718	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,089	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	70	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 70	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	3,042	28
28a	<u>Miscellaneous and Illinois Cares Revenue</u>	913,385	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 916,427	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,405,656	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	627,552	31
32	Health Care	1,405,440	32
33	General Administration	472,161	33
	B. Capital Expense		
34	Ownership	479,529	34
	C. Ancillary Expense		
35	Special Cost Centers	119,340	35
36	Provider Participation Fee	157,210	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,261,232	40
41	Income before Income Taxes (line 30 minus line 40)**	1,144,424	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,144,424	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,894,011	44
45	Private Pay - Net Inpatient Revenue	797,330	45
46	Medicare - Net Inpatient Revenue	364,668	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	8,931	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,064,940	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	2,080	2,080	\$ 74,000	\$ 35.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,876	7,063	217,928	30.85	3
4	Licensed Practical Nurses	6,814	7,024	167,418	23.84	4
5	CNAs & Orderlies	22,919	23,603	383,306	16.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,804	1,880	23,175	12.33	9
10	Activity Assistants	66	66	737	11.17	10
11	Social Service Workers	1,713	1,847	27,870	15.09	11
12	Dietician					12
13	Food Service Supervisor	2,042	2,086	31,972	15.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,209	12,764	120,474	9.44	15
16	Dishwashers					16
17	Maintenance Workers	1,770	1,887	47,530	25.19	17
18	Housekeepers	8,488	8,954	117,703	13.15	18
19	Laundry	1,930	2,080	41,254	19.83	19
20	Administrator	2,080	2,112	60,000	28.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,817	1,987	31,007	15.60	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	484	484	15,961	32.98	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	55	55	1,357	24.67	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,669	4,828	88,661	18.36	33
34	TOTAL (lines 1 - 33)	77,816	80,800	\$ 1,450,353 *	\$ 17.95	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,578	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	20	1,349	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	20	\$ 18,927		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	1,535	106,149	L10,C3	51
52	Certified Nurse Assistants/Aides	1,505	57,497	L10,C3	52
53	TOTAL (lines 50 - 52)	3,040	\$ 163,646		53

Roseville Rehab Health Care
0050849
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,828	1,828	49,901	27.30
Transportation	1,672	1,747	20,105	11.51
Marketing	1,169	1,253	18,655	14.89
TOTAL	4,669	4,828	88,661	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Job Runge	Administrator	0	\$ 60,000	Workers' Compensation Insurance	\$	23,972	IDPH License Fee	\$	
				Unemployment Compensation Insurance		8,210	Advertising: Employee Recruitment		
				FICA Taxes		103,715	Health Care Worker Background Check		
				Employee Health Insurance		2,348	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	46 1,380	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	361	
				Employee Relations		677	Home Office Allocation	2,495	
				Home Office Allocation		8,297			
				Administrator Benefits		12,000			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,000				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
Description			Amount				Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 175,100						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 175,100				TOTAL (agree to Sch. V, line 20, col. 8) \$ 4,236		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frontier	Computer Services	\$	946			\$	Out-of-State Travel	\$	
Ability Network	Computer Services		4,538						
Shirley Litwiler	Legal Settlement		20,000						
Mediacom	Computer Services		1,905				In-State Travel		
Ginoli and Company	Accounting Fees		4,600						
				N/A					
							Seminar Expense	20	
							Home Office Allocation	16	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 31,989	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 36	

*** Attach copy of IMRF notifications**

****See instructions.**

Roseville Rehab Health Care

0050849

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)		31,989
Less Non-Allowable Legal Settlement		(20,000)
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	282
Duane Morris	Legal	394
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	15
Miller, Hall, Triggs	Legal	49
Miscellaneous	Legal	18
SB2	Legal	146
SmithAmundsen LLC	Legal	901
Sorling Northrup	Legal	257
CliftonLarsonAllen	Accounting	1,119
Ginoli & Co.	Accounting	799
Ability Network	Computer Services	2,873
Allscripts	Computer Services	454
AOD Matrix Care	Computer Services	5,046
AT&T	Computer Services	5
ATS	Computer Services	275
CCH	Computer Services	16
Charter Communications	Computer Services	25
Citrix Systems	Computer Services	86
Comcast	Computer Services	29
ITSavvy	Computer Services	133
Kemper Technology	Computer Services	656
Miscellaneous	Computer Services	187
Pearl Technology	Computer Services	119
Stratus Networks	Computer Services	521
TR Professional	Computer Services	11
David Budde	Other Prof Fees	12
DJ Howard and Associates	Other Prof Fees	22
Getzler Henrich & Associates	Other Prof Fees	89
LRI Consulting Services	Other Prof Fees	86
McQuellon Consulting	Other Prof Fees	55
Miscellaneous	Other Prof Fees	43
Optimizer	Other Prof Fees	47
Registered Agent Solutions	Other Prof Fees	26
RSM McGladrey	Other Prof Fees	285
SB2	Other Prof Fees	364
Sedgwick CMS	Other Prof Fees	491
Tarver Program Consultants	Other Prof Fees	68
Total (agree to Schedule V, line 19, column 8)		<u>28,001</u>

Roseville Rehab Health Care
0050849

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

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	4,014
Auto Repairs		997
Mileage-Travel		1,574
Home Office Allocation		<u>3,492</u>
		<u>10,077</u>

XX. GENERAL INFORMATION:

- | | |
|---|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7 yrs.</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>18,179</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>157,210</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>5,133</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>Yes</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>3,042</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u>
d. Have vehicle usage logs been maintained? <u>Yes</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>Ginoli and Company</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>No</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|---|---|