

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 0056630

Facility Name: Manor Court of Rochelle

Address: 2203 Flagg Road Rochelle 61068

NumberCityZip Code

County: Ogle

Telephone Number: (815) 562-9800 Fax # (815) 562-9899

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2020

Type of Ownership:

☒

VOLUNTARY, NON-PROFIT

☒

Charitable Corp.

☐

Trust

IRS Exemption Code 501 (c) 3

☐

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: Brian BurgerTelephone Number: (309) 343-1550Email 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 4/1/2024 to 3/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Rochelle

0056630

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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

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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9		
Level of Care	Patient Days by Level of Care and Primary Source of Payment									
	Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total		
			Medicaid Primary	Medicare Primary						
8	SNF	3,842	4,071	2,060		13,631	2,947	922	27,473	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,842	4,071	2,060		13,631	2,947	922	27,473	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

81.81%

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

0 (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/1/20

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 92

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 3/31/25 Fiscal Year: 3/31/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Manor Court of Rochelle

0056630

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	295,750	30,047	10,752	336,549		336,549		336,549			1
2	Food Purchase		309,014		309,014		309,014		309,014			2
3	Housekeeping	196,897	34,332		231,229		231,229		231,229			3
4	Laundry	55,346	18,530		73,876		73,876		73,876			4
5	Heat and Other Utilities			149,528	149,528		149,528		149,528			5
6	Maintenance	123,534	21,510	117,411	262,455		262,455	(2,703)	259,752			6
7	Other (specify):*											7
8	TOTAL General Services	671,527	413,433	277,691	1,362,651		1,362,651	(2,703)	1,359,948			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,901,652	194,362	734,556	3,830,570		3,830,570		3,830,570			10
10a	Therapy											10a
11	Activities	108,331	3,567		111,898		111,898		111,898			11
12	Social Services	48,101			48,101		48,101		48,101			12
13	CNA Training			6,391	6,391		6,391		6,391			13
14	Program Transportation			4,808	4,808		4,808		4,808			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,058,084	197,929	763,755	4,019,768		4,019,768		4,019,768			16
	C. General Administration											
17	Administrative	107,494			107,494		107,494		107,494			17
18	Directors Fees							1,978	1,978			18
19	Professional Services			187,808	187,808		187,808	1,107	188,915			19
20	Dues, Fees, Subscriptions & Promotions			42,262	42,262		42,262	(2,840)	39,422			20
21	Clerical & General Office Expenses	177,250	30,764	67,573	275,587		275,587	434	276,021			21
22	Employee Benefits & Payroll Taxes			553,761	553,761		553,761		553,761			22
23	Inservice Training & Education			5,826	5,826		5,826		5,826			23
24	Travel and Seminar			148	148		148		148			24
25	Other Admin. Staff Transportation			509	509		509		509			25
26	Insurance-Prop.Liab.Malpractice			127,893	127,893		127,893	1,231	129,124			26
27	Other (specify):*											27
28	TOTAL General Administration	284,744	30,764	985,780	1,301,288		1,301,288	1,910	1,303,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,014,355	642,126	2,027,226	6,683,707		6,683,707	(793)	6,682,914			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
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			1,060,072	1,060,072		1,060,072	2,939	1,063,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			158,760	158,760		158,760	(9,532)	149,228			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,591	10,591		10,591		10,591			35
36	Other (specify):*											36
37	TOTAL Ownership			1,229,423	1,229,423		1,229,423	(6,593)	1,222,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,058	2,058		2,058		2,058			38
39	Ancillary Service Centers		95,774	672,824	768,598		768,598	(1,309)	767,289			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			425,397	425,397		425,397		425,397			42
43	Other (specify):* Disallowed Costs	61,355		186,066	247,421		247,421	(247,421)				43
44	TOTAL Special Cost Centers	61,355	95,774	1,286,345	1,443,474		1,443,474	(248,730)	1,194,744			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,075,710	737,900	4,542,994	9,356,604		9,356,604	(256,116)	9,100,488			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,153)	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	2,939	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
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	(250)	20		17
18	Fines and Penalties	(9,691)	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	(127,093)	43		24
25	Fund Raising, Advertising and Promotional	(16,912)	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 See Page 5A	(104,732)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,892)		\$	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)	4,776		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,776		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (256,116)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (2,616)	20
2	Other Expenses Related to Lobbying Activities		
3	Disallow Marketing Salary	(61,355)	43
4	Disallow Medicare Pt. A Lab	(22,453)	43
5	Disallow Medicare Pt. A X-Ray	(4,764)	43
6	Offset Miscellaneous Income	(1,309)	39
7	Capitalize Repair over \$2,500	(2,703)	6
8	Disallow Late Penalty on RE Taxes	(9,532)	33
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49	Total	(104,732)	

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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Residential Alternatives of Illinois, Inc. (FH is sole mem				
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 1,978	\$ 1,978	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	1,107	1,107	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	26	26	3
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	434	434	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,231	1,231	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 4,776	\$ * 4,776	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Rochelle

0056630

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville				1
2	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton				2
3	Residential Alternatives of Illinois	100%	Manor Court of Clinton-Sold in 2025	Clinton				3
4	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru				4
5	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport				5
6	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria				6
7	Residential Alternatives of Illinois	100%			Hawthorne Inn of Freeport, IL	Freeport, IL	Supportive Living Facility	7
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peoria, IL	Peoria, IL	Assisted Living Facility	8
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru, IL	Peru, IL	Assisted Living Facility	9
10	Residential Alternatives of Illinois	100%			Liberty Estates of Geneseo, IL	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%			Liberty Estates of Streator, IL	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%			Liberty Estates of Danville, IL	Danville, IL	Independent Living	12
13	Residential Alternatives of Illinois	100%			Liberty Estates of Freeport, IL	Freeport, IL	Independent Living	13
14	Residential Alternatives of Illinois	100%			Liberty Estates of Peoria, IL	Peoria, IL	Independent Living	14
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peru, IL	Peru, IL	Independent Living	15
16	Residential Alternatives of Illinois	100%	Windmill Manor	Coralville IA				16
17	Residential Alternatives of Illinois	100%			Hawthorne Inn of Rochelle, IL	Rochelle, IL	Assisted Living Facility	17
18	Frances House, Inc.	100%	Casa Willis	Sterling, IL	Woodburn	Sterling, IL	CILA	18
19	Frances House, Inc.	100%	Freeport Terrace	Freeport, IL				19
20	Frances House, Inc.	100%	Gordon Jones Terrace	Lanark, IL				20
21	Frances House, Inc.	100%	Hallam Terrace	Rockford, IL				21
22	Frances House, Inc.	100%	Hammett House	Sterling, IL				22
23	Frances House, Inc.	100%	Kanthak House	Ottawa, IL				23
24	Frances House, Inc.	100%	Olson Terrace	Rockford, IL				24
25	Frances House, Inc.	100%	Ridge Terrace	Freeport, IL				25
26	Frances House, Inc.	100%	Cantebury Place	Rockford, IL				26
27	Frances House, Inc.	100%	Glenwood Villa	Rockford, IL				27
28	Frances House, Inc.	100%	Rockton Court	Rockford, IL				28
29	Frances House, Inc.	100%	Rose House	Moline, IL				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Rochelle

0056630

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Frances House, Inc.	100%	Seborg Terrace	Rockford, IL				1
2	Frances House, Inc.	100%	Smith Square	Moline, IL				2
3	Frances House, Inc.	100%	Stern Square	Sterling, IL				3
4	Frances House, Inc.	100%	Stouffer Terrace	Oregon, IL				4
5	Frances House, Inc.	100%	Lewis Terrace	North Chicago, IL				5
6	Frances House, Inc.	100%	Seymour Terrace	North Chicago, IL				6
7	Frances House, Inc.	100%	Waukegan Terrace	Waukegan, IL				7
8	Frances House, Inc.	100%	Pine Terrace	Waukegan, IL				8
9	Pioneer Concepts, Inc.	100%	Broadway Terrace	Chicago Heights, IL	Woodgate	Matteson	CILA	9
10	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL	Thornton	Thornton	CILA	10
11	Pioneer Concepts, Inc.	100%	Flossmoor Terrace	Flossmoor, IL				11
12	Pioneer Concepts, Inc.	100%	Ravisloe Terrace	Country Club Hills, IL				12
13	Pioneer Concepts, Inc.	100%	Spaulding Terrace	Markham, IL				13
14	Pioneer Concepts, Inc.	100%	Calumet City Terrace	Calumet City, IL				14
15	Pioneer Concepts, Inc.	100%	Dolton Terrace	Dolton, IL				15
16	Pioneer Concepts, Inc.	100%	Lynwood Terrace	Lynwood, IL				16
17	Pioneer Concepts, Inc.	100%	Holland Terrace	South Holland, IL				17
18	Pioneer Concepts, Inc.	100%	Matteson Court	Matteson, IL				18
19	Pioneer Concepts, Inc.	100%	Priarie House	Sauk Village, IL				19
20	Pioneer Concepts, Inc.	100%	Torrence Place	Sauk Village, IL				20
21	Pinnacle Opportunities	100%	Chambness Square	Bourbannais, IL	Gravlin Square	Bradley, IL	CILA	21
22	Pinnacle Opportunities	100%	Collins Square	Bradley, IL				22
23	Pinnacle Opportunities	100%	Dearborn Court	Kankakee, IL				23
24	Pinnacle Opportunities	100%	River Court	Kankakee, IL				24
25	Pinnacle Opportunities	100%	Station Court	Kankakee, IL				25
26	Pinnacle Opportunities	100%	Eagle Court	Kankakee, IL				26
27	Pinnacle Opportunities	100%	Kankakee Court	Kankakee, IL				27
28	Pinnacle Opportunities	100%	Roy Court	Bourbannais, IL				28
29	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 396	L18, C7	1
2	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	396	L18, C7	2
3	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	396	L18, C7	3
4	Marilyn Holt	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	395	L18, C7	4
5	Wayne Stone	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	395	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 1,978		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 Manor Court of Rochelle # 0056630 Report Period Beginning: 4/1/2024 Ending: 3/31/2025

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 Residential Alternatives of Illinois, Inc.
Street Address 285 S. Farnham
City / State / Zip Code Galesburg, IL 61401
Phone Number (309) 343-1550
Fax Number (309) 343-2857

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avg BDA	382,040	20	\$ 22,500	\$	33,580	\$ 1,978	1
2	19	Professional Services	Weighted Avg BDA	382,040	20	12,600		33,580	1,107	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	382,040	20	300		33,580	26	3
4	21	Clerical & General Office	Weighted Avg BDA	382,040	20	4,930		33,580	434	4
5	26	Property Insurance	Weighted Avg BDA	382,040	20	14,007		33,580	1,231	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 54,337	\$		\$ 4,776	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	N/A												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													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

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

** 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	314,569	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.)		2023		\$	263,718	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(50,851)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	302,851	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.		Disallow Assisted Living Portion			(93,240)	
		Disallow Late Pymt Penalty			(9,532)	
TOTAL REFUND \$ For 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.				\$	149,228	7
Assessed Value from Real Estate Tax Bill:		2024	4,286,345	8		
Real Estate Tax Bill for Calendar Year:		2020	220,162	9		
		2021	230,358	10		
		2022	250,209	11		
		2023	254,185	12		
		2024	240,452	13		
Amount accrued includes 12 months of 2024 and 3 months of 2025.						
The real estate tax estimated is based on the 2024 tax bill.						
Taxes paid are for the 2023 tax bill.						

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

FACILITY NAME	<u>Manor Court of Rochelle</u>	COUNTY	<u>Ogle</u>
---------------	--------------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Brian Burger

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,770 B. General Construction Type: Exterior Vinyl Siding/Brick Ven Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	13.64 Acres		2018		\$ 107,100	
2							
3	TOTALS	#VALUE!				\$ 107,100	

SEE ACCOUNTANTS' PREPARATION REPORT

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	92			2020	\$ 17,089,059	\$ 683,568	25	\$ 683,568	\$	\$ 3,313,741	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Infrastructure/Development			2020	2,288,640	114,422	20	114,422		553,077	9
10	Landscaping-Trees/Shrubs/Sod/Mulch/Brick Edging/Bedrock			2020	239,770	11,987	20	11,987		57,941	10
11	Parking Lot/Main Road Repair			2020	27,400	3,427	8	3,427		15,407	11
12	Electrical Work-Kitchen Panel and Circulating Pump on Emergency Pow			2021	19,780	1,979	10	1,979		6,754	12
13	Repair Furnace			2021	3,098		5	620	620	2,170	13
14	Repair 2 AC Units			2021	2,925		5	585	585	2,048	14
15	Repair 2 Daikin HVAC Units			2022	3,989		5	798	798	1,995	15
16	New Condensing Unit - Service Hallway			2023	5,284	352	15	352		658	16
17	Repair Air Conditioner			2023	10,674	2,135	5	2,135		3,558	17
18	Replace Gas Valve in Furnace			2023	3,429		10	343	343	514	18
19	Install RSMD Module for Compressor Unit			2024	2,884	168	10	168		168	19
20	Repair Two Backflow Prevention Assemblies			2024	3,037	127	10	127		127	20
21	Install Rooftop AC Unit - East of Main Entrance			2024	3,195	107	10	107		107	21
22	Install Blower Motor on HVAC - Southside Therapy Rm			2025	6,896	172	10	172		172	22
23	Repair Air Conditioner Leak			2024	2,703		5	270	270	270	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

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)		\$ 19,712,763	\$ 818,444		\$ 821,060	\$ 2,616	\$ 3,958,707	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 2,298,478	\$ 234,830	\$ 235,153	\$ 323	5-15 yrs	\$ 1,110,942	71
72	Current Year Purchases	13,370	384	384		5-10 yrs	384	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,311,848	\$ 235,214	\$ 235,537	\$ 323		\$ 1,111,326	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 Use	2020 Toyota Corolla	2023	\$ 19,145	\$ 4,788	\$ 4,788	\$	4	\$ 10,374	76
77	Facility Use	2008 Chevy Silverado 2500	2024	13,000	1,626	1,626		4	1,626	77
78										78
79										79
80	TOTALS			\$ 32,145	\$ 6,414	\$ 6,414	\$		\$ 12,000	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,163,856	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,060,072	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,063,011	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,939	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,082,033	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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- Facility Owned
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 .
N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 10,591 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	N/A				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.

Facility Name:

Manor Court of Rochelle

IDPH License ID Number:

0056630

Fiscal Year End:

3/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	10,291
Other Equipment Rental	300
Total - Line 16	10,591

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 5,993	\$	\$ 5,993
2	Books and Supplies		398		398
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	\$	\$ 6,391	\$	\$ 6,391
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,391			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,736	\$ 268,970	\$	3,736	\$ 268,970	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,833	131,950		1,833	131,950	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(3)	hrs		3,776	271,904		3,776	271,904	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				95,774		95,774	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			\$	9,345	\$ 672,824	\$ 95,774	9,345	\$ 768,598	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 207,428	\$ 207,428	1
2	Cash-Patient Deposits	28,082	28,082	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,000)	543,671	543,671	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,498	22,498	6
7	Other Prepaid Expenses	1,162	1,162	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 802,841	\$ 802,841	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		107,100	13
14	Buildings, at Historical Cost	17,168,209	17,184,353	14
15	Leasehold Improvements, at Historical Cost	2,528,410	2,528,410	15
16	Equipment, at Historical Cost	2,340,760	2,343,993	16
17	Accumulated Depreciation (book methods)	(5,084,186)	(5,082,033)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,953,193	\$ 17,081,823	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,756,034	\$ 17,884,664	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 285,500	\$ 285,500	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,082	28,082	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,769	96,769	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	302,851	302,851	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>	22,751,372	22,751,372	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 23,464,574	\$ 23,464,574	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	<u>Security Deposits</u>	51,000	51,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 51,000	\$ 51,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 23,515,574	\$ 23,515,574	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,759,540)	\$ (5,630,910)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,756,034	\$ 17,884,664	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,415,927)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,415,928)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(343,612)	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)	\$ (343,612)	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)	\$ (5,759,540)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Rochelle

0056630

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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	\$ 8,598,441	1
2	Discounts and Allowances for all Levels	(32,380)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,566,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	425,602	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 425,602	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	2,077	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,226	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,303	23
	D. Non-Operating Revenue		
24	Contributions	2,840	24
25	Interest and Other Investment Income***	1,091	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,931	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,309	28
28a	See Attached Sch 19A	10,786	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,095	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,012,992	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,362,651	31
32	Health Care	4,019,768	32
33	General Administration	1,301,288	33
	B. Capital Expense		
34	Ownership	1,229,423	34
	C. Ancillary Expense		
35	Special Cost Centers	1,018,077	35
36	Provider Participation Fee	425,397	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,356,604	40
41	Income before Income Taxes (line 30 minus line 40)**	(343,612)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (343,612)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,048,825.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,040,831.00	45
46	MMAI-Medicaid is the Primary Payer	562,358.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,970,811.00	48
49	Medicare Part A	1,606,115.00	49
50	Other-(specify) Medicare Replacement/Managed Care	185,614.00	50
51	Other-(specify) Hospice	151,507.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,566,061	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:Manor Court of Rochelle

IDPH License ID Number:0056630

Fiscal Year End:3/31/2025

Schedule 19A

XVII. Income Statement

Line 28a Other Income

Rental Description	Amount
Carport Rental	10,680
Processing/Late Fees	106
Total - Line 28a	10,786

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	1,136	1,349	\$ 72,238	\$ 53.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,976	13,569	572,447	42.19	3
4	Licensed Practical Nurses	8,320	8,762	268,454	30.64	4
5	CNAs & Orderlies	79,394	83,901	1,959,730	23.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,127	6,452	108,331	16.79	10
11	Social Service Workers	2,534	2,754	48,101	17.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,252	19,236	295,750	15.37	15
16	Dishwashers					16
17	Maintenance Workers	5,113	5,435	123,534	22.73	17
18	Housekeepers	10,667	11,223	196,897	17.54	18
19	Laundry	2,718	2,718	55,346	20.36	19
20	Administrator	1,920	2,080	107,494	51.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,018	8,715	177,250	20.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,514	1,625	28,783	17.71	31
32	Other Health Care(specify)					32
33	Other(specify)Marketing	2,144	2,368	61,355	25.91	33
34	TOTAL (lines 1 - 33)	160,833	170,187	\$ 4,075,710 *	\$ 23.95	34

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	Monthly	\$ 10,752	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,623	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,375		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,865	\$ 480,950	L10, C3	50
51	Licensed Practical Nurses	3,597	244,615	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,462	\$ 725,565		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	4,990
	4,990 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	2,616
	2,616 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	7,606
	7,606 Total
- (5)

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

\$ 48,769 Line 10
- (6)

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

Yes

If NO, attach a complete explanation.
- (7)

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

\$ 425,397

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs? Indicate the amount. \$ N/A
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

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

100% Line 14

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?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13)

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

Yes

Firm Name: RSM US LLP
- (14)

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

Yes
- (15)

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.

N/A

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