



Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,985	4,730	2,148	11,863	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,985	4,730	2,148	11,863	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.00%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/31/2006

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 50 and days of care provided 1,948

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	92,721	5,773	1,458	99,952		99,952	2,299	102,251		1
2	Food Purchase		88,202		88,202		88,202	(400)	87,802		2
3	Housekeeping	107,445	18,978		126,423		126,423	18	126,441		3
4	Laundry	5,613	5,511		11,124		11,124		11,124		4
5	Heat and Other Utilities			58,119	58,119		58,119	132	58,251		5
6	Maintenance	14,639	9,417	18,196	42,252		42,252	912	43,164		6
7	Other (specify):* Home Office Ben. Allocation										7
8	<b>TOTAL General Services</b>	220,418	127,881	77,773	426,072		426,072	2,961	429,033		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	738,158	76,017	2,794	816,969		816,969	40	817,009		10
10a	Therapy			237,690	237,690		237,690		237,690		10a
11	Activities	24,444	196	496	25,136		25,136	(1,615)	23,521		11
12	Social Services	26,700	31		26,731		26,731		26,731		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	<b>TOTAL Health Care and Programs</b>	789,302	76,244	258,980	1,124,526		1,124,526	(1,575)	1,122,951		16
	<b>C. General Administration</b>										
17	Administrative			225,100	225,100		225,100	(157,236)	67,864		17
18	Directors Fees										18
19	Professional Services			6,562	6,562		6,562	25,854	32,416		19
20	Dues, Fees, Subscriptions & Promotions			5,502	5,502		5,502	759	6,261		20
21	Clerical & General Office Expenses	18,663	2,297	9,289	30,249		30,249	25,697	55,946		21
22	Employee Benefits & Payroll Taxes			129,259	129,259		129,259	17,729	146,988		22
23	Inservice Training & Education							177	177		23
24	Travel and Seminar							40	40		24
25	Other Admin. Staff Transportation			1,628	1,628		1,628	1,809	3,437		25
26	Insurance-Prop.Liab.Malpractice			29,557	29,557		29,557	278	29,835		26
27	Other (specify):* Home Office Ben. Allocation										27
28	<b>TOTAL General Administration</b>	18,663	2,297	406,897	427,857		427,857	(84,893)	342,964		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,028,383	206,422	743,650	1,978,455		1,978,455	(83,507)	1,894,948		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			102,902	102,902		102,902	32,920	135,822			30
31	Amortization of Pre-Op. & Org.							8,785	8,785			31
32	Interest			97,094	97,094		97,094	6,811	103,905			32
33	Real Estate Taxes			37,275	37,275		37,275	301	37,576			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,985	26,985		26,985	349	27,334			35
36	Other (specify):* Home Office Ben. Allocation											36
37	<b>TOTAL Ownership</b>			264,256	264,256		264,256	49,166	313,422			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,075		54,075		54,075		54,075			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,343	86,343		86,343		86,343			42
43	Other (specify):* Home Office Ben. Allocati		298	41,499	41,797		41,797	(41,797)				43
44	<b>TOTAL Special Cost Centers</b>		54,373	127,842	182,215		182,215	(41,797)	140,418			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,028,383	260,795	1,135,748	2,424,926		2,424,926	(76,138)	2,348,788			45

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

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(404)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,211)	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	28,045	30		9
10	Interest and Other Investment Income	(349)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29)	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	(21,911)	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				24
25	Fund Raising, Advertising and Promotional	(2,317)	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	(11,302)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (16,478)		\$	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(59,660)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (59,660)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (76,138)		37

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

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

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

Rochelle Rehab & Hlthcare Cr

ID# 0050856

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (4,548)	43	1
2	X-Rays-Part A	(3,815)	43	2
3	Resident Flowers	(237)	43	3
4	Offset Miscellaneous Nursing Supplies Revenue	(30)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(78)	21	5
6	Disallowed Special Events	(729)	43	6
7	Offset Transportation Revenue	(1,615)	11	7
8	Disallowed Chamber of Commerce Dues	(250)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(11,302)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	116	116	12
13	V							13
14	Total		\$			\$ 116	\$ *	116 14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 31	\$	31	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	0			16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0			17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0			18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	0			19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0			20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0			21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0			22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	449		449	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	0			24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0			26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 480	\$ *	480	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	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	21,671	21,671	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	905	905	26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	492	492	28	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	297	297	33	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	8,785	8,785	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	7,027	7,027	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 39,177	\$ *	39,177	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	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,299	\$ 2,299
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	18	18
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	132	132
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	912	912
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	70	70
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	225,100	Petersen Health Care Management, Inc.	100.00%	67,864	(157,236)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	4,067	4,067
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	73	73
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,775	25,775
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,237	17,237
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	177	177
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	40	40
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,809	1,809
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	278	278
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	4,129	4,129
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	133	133
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	301	301
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	349	349
39	Total		\$ 225,100			\$ 125,667	\$ * (99,433)

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

Facility Name &amp; ID Number

Rochelle Rehab &amp; Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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 J	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	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 &amp; ID Number

Rochelle Rehab &amp; Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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 &amp; ID Number

Rochelle Rehab &amp; Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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

Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr # 0050856 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 0	\$ 0	11,863	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	11,863	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	11,863	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	11,863	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	11,863	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	11,863	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	11,863	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	11,863	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	11,863	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	11,863	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	11,863	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	11,863	116	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	11,863	31	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	11,863	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	11,863	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	11,863	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	11,863	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	11,863	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	11,863	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	11,863	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	11,863	449	21
22	32	Interest	Resident Days	1,553,881	75	0	0	11,863	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	11,863	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	11,863	0	24
25	TOTALS					\$ 78,110	\$		\$ 596	25

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856 Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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

Name of Related Organization Petersen Health Network, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309)691-8113  
 Fax Number (309)691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	259,904	13		11,863		1
2	2	Food	Resident Days	259,904	13		11,863		2
3	3	Housekeeping	Resident Days	259,904	13		11,863		3
4	4	Laundry	Resident Days	259,904	13		11,863		4
5	5	Utilities	Resident Days	259,904	13		11,863		5
6	6	Maintenance	Resident Days	259,904	13		11,863		6
7	7	Mgmt. Allocation of Benefits	Resident Days	259,904	13		11,863		7
8	10	Nursing and Medical Records	Resident Days	259,904	13		11,863		8
9	15	Mgmt. Allocation of Benefits	Resident Days	259,904	13		11,863		9
10	17	Administrative	Resident Days	259,904	13		11,863		10
11	19	Professional Services	Resident Days	259,904	13	474,776	11,863	21,671	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	259,904	13	19,824	11,863	905	12
13	21	Clerical and General Office	Resident Days	259,904	13		11,863		13
14	22	Employee Benefits & Payroll	Resident Days	259,904	13	10,774	11,863	492	14
15	23	Inservice Training & Education	Resident Days	259,904	13		11,863		15
16	24	Travel and Seminar	Resident Days	259,904	13		11,863		16
17	25	Other Admin. Staff Transport.	Resident Days	259,904	13		11,863		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	259,904	13		11,863		18
19	30	Depreciation	Resident Days	259,904	13	6,500	11,863	297	19
20	31	Amortization	Resident Days	259,904	13	192,475	11,863	8,785	20
21	32	Interest	Resident Days	259,904	13	153,955	11,863	7,027	21
22	33	Real Estate Taxes	Resident Days	259,904	13		11,863		22
23	34	Rent-Facility and Grounds	Resident Days	259,904	13		11,863		23
24	35	Rent-Equipment & Vehicles	Resident Days	259,904	13		11,863		24
25	TOTALS					\$ 858,304	\$	\$ 39,177	25

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856 Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 301,135	\$ 292,840	11,863	\$ 2,299	1
2	2	Food	Resident Days	1,553,881	75	480		11,863	4	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	11,863	18	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		11,863	132	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	11,863	912	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			11,863		6
7	9	Medical Director	Resident Days	1,553,881	75			11,863		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		11,863	70	8
9	10A	Therapy	Resident Days	1,553,881	75			11,863		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			11,863		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	11,863	67,864	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		11,863	4,067	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		11,863	73	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	11,863	25,775	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		11,863	17,237	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		11,863	177	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		11,863	40	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		11,863	1,809	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		11,863	278	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			11,863		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		11,863	4,129	21
22	32	Interest	Resident Days	1,553,881	75	17,439		11,863	133	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		11,863	301	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		11,863	349	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 125,667	25

Facility Name & ID Number

Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**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	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 2,153,361	\$ 2,002,626	12/31/34	Varies	\$ 97,094	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 2,153,361	\$ 2,002,626			\$ 97,094	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 6,811	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,153,361	\$ 2,002,626			\$ 103,905	15						

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

\*\* 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**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>																																				
1. Real Estate Tax accrual used on 2014 report.		\$ <b>41,292</b>	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.)		\$ <b>38,703</b>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(2,589)</b>	3																																	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>39,864</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	<b>Home Office Allocation</b>	<b>301</b>	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>37,576</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td><u>41,138</u></td><td>8</td></tr> <tr><td>2011</td><td><u>39,456</u></td><td>9</td></tr> <tr><td>2012</td><td><u>39,200</u></td><td>10</td></tr> <tr><td>2013</td><td><u>40,087</u></td><td>11</td></tr> <tr><td>2014</td><td><u>38,703</u></td><td>12</td></tr> </table>	2010	<u>41,138</u>	8	2011	<u>39,456</u>	9	2012	<u>39,200</u>	10	2013	<u>40,087</u>	11	2014	<u>38,703</u>	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2014	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2010	<u>41,138</u>	8																																		
2011	<u>39,456</u>	9																																		
2012	<u>39,200</u>	10																																		
2013	<u>40,087</u>	11																																		
2014	<u>38,703</u>	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2014	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<b>Accrual based on prior year tax bill.</b>																																				

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rochelle Rehab & Hlthcare Cr COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0050856

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

TELEPHONE (309)691-8113 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>24-24-179-007</u>	<u>Long-Term Care Facility</u>	\$ <u>38,702.74</u>	\$ <u>38,702.74</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>38,702.74</u></u>	\$ <u><u>38,702.74</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 a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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: 14,800 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20  
 3. Current Period Amortization: 8,785 4. Dates Incurred: 2013-2014

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>52,272</u>	<u>2006</u>	<u>\$ 90,000</u>	1
2					2
3	<b>TOTALS</b>	<u>52,272</u>		<u>\$ 90,000</u>	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	50	2006		\$ 2,182,000	\$	30	\$ 72,733	\$ 72,733	\$ 690,964	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Remodel Shower		2007	35,270		15	2,351	2,351	19,984	9
10	Draperies		2007	1,419		10	142	142	1,207	10
11	Carpeting		2007	9,122		10	912	912	7,752	11
12	Office Room Installation		2007	2,075		15	138	138	1,173	12
13	Exterior Sign		2007	4,130		15	275	275	2,338	13
14	Painting of 10 Rooms		2007	6,175		15	412	412	3,502	14
15	Wallpaper In Living Room, Dining Room, TV Room		2007	3,638		15	243	243	2,065	15
16	Flooring for Dining Room		2007	2,681		15	179	179	1,522	16
17	Rooftop Unit		2008	6,965		15	464	464	3,480	17
18	Fire Alarm Panel Replacement		2010	3,315		7	474	474	2,607	18
19	Engineering for Sprinkler Work		2011	3,750		15	250	250	1,125	19
20	Sprinkler System Replacement		2012	64,950		15	4,330	4,330	15,155	20
21	Water softener		2014	5,052		7	722	722	1,083	21
22	Flooring and New Shower Install-South Shower Room		2014	3,812		7	545	545	818	22
23	Glass Door Install, Flooring, Drywall Remodel-Dining Room		2014	18,511		15	1,234	1,234	1,851	23
24	Gas Pipe Repairs		2015	6,450		7	461	461	461	24
25	Roof Replacement		2015	27,420		25	549	549	549	25
26										26
27										27
28										28
29										29
30										30
31	Building Booked				87,280			(87,280)		31
32	Building Improvement Booked				11,299			(11,299)		32
33										33
34	2015-Home Office Allocation-Building Improvements			5,191			124	124		34
35	2015-Home Office Allocation-Land Improvements			485			31	31		35
36										36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,392,411	\$ 98,579		\$ 86,568	\$ (12,011)	\$ 757,635	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	\$ 445,325	\$ 4,323	\$ 44,534	\$ 40,211	5-10 yrs.	\$ 405,448	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,720	4,720			74
75	TOTALS	\$ 445,325	\$ 4,323	\$ 49,254	\$ 44,931		\$ 405,448	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Ford Econoline Van	2007	\$ 28,738	\$	\$	\$		\$ 28,738	76
77										77
78										78
79										79
80	TOTALS			\$ 28,738	\$	\$	\$		\$ 28,738	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)	\$ 2,956,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,902	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,822	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,920	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,191,821	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	N/A		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.

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

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

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

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

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: \$ 22,402 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	Facility	2012 Ford E250	\$ 411.02	\$ 4,932	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 411.02	\$ 4,932	21

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

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

**Rochelle Rehab & Hlthcare Cr  
0050856**

**Period Beginning**     **1/1/2015**  
**Period End**           **12/31/2015**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 17,559
Dishwasher	716
Maintenance Equip.	37
Copier	3,741
Home Office Allocation	349
	<u>22,402</u>

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr # 0050856 Report Period Beginning: 1/1/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,609	\$ 99,131	\$	6,609	\$ 99,131	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		860	12,905		860	12,905	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,377	125,654		8,377	125,654	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				54,075		54,075	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	<b>TOTAL</b>			\$	15,846	\$ 237,690	\$ 54,075	15,846	\$ 291,765	14

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

Facility Name & ID Number **Rochelle Rehab & Hlthcare Cr**# **0050856**Report Period Beginning: **1/1/2015**

Ending:

**12/31/2015****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 920,494	\$ 920,494	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <b>14,296</b> )	601,538	601,538	3
4	Supply Inventory (priced at <b>Cost</b> )	6,814	6,814	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,311	22,311	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Security Deposit, PPD Lease</b>	6,726	6,726	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,557,883	\$ 1,557,883	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,000	90,000	13
14	Buildings, at Historical Cost	2,182,000	2,187,191	14
15	Leasehold Improvements, at Historical Cost	203,316	205,220	15
16	Equipment, at Historical Cost	474,063	474,063	16
17	Accumulated Depreciation (book methods)	(1,327,916)	(1,191,821)	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 (spec <b>A/R-Prior Owner</b> )	9,843	9,843	22
23	Other(specify): <b>Intercompany Loans</b>	63,148	63,148	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,694,454	\$ 1,837,644	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,252,337	\$ 3,395,527	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 480,838	\$ 480,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,844	56,844	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,022	35,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,864	39,864	32
33	Accrued Interest Payable	8,184	8,184	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Payroll Withholdings</b>	13,245	13,245	36
37	<b>Accrued Management Fees</b>	34,145	34,145	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 668,142	\$ 668,142	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,002,626	2,002,626	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,002,626	\$ 2,002,626	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,670,768	\$ 2,670,768	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 581,569	\$ 724,759	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,252,337	\$ 3,395,527	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>591,056</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment Made After Cost Report Was Filed</b>	<b>591</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>591,647</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(10,078)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(10,078)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>581,569</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,072,963	1
2	Discounts and Allowances for all Levels	(214,674)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,858,289</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	431,794	6
7	Oxygen	3,443	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 435,237</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	404	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,671	20
21	Other Medical Services	7,440	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 119,250</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	349	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 349</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	1,615	28
28a	<u>Miscellaneous Revenue</u>	108	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,723</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,414,848</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	426,072	31
32	Health Care	1,124,526	32
33	General Administration	427,857	33
<b>B. Capital Expense</b>			
34	Ownership	264,256	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	95,872	35
36	Provider Participation Fee	86,343	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,424,926</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(10,078)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (10,078)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 720,600	44
45	Private Pay - Net Inpatient Revenue	674,613	45
46	Medicare - Net Inpatient Revenue	427,620	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	37,663	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(2,207)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,858,289</b>	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.

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr

# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**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	\$ 69,592	\$ 33.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,708	8,858	228,822	25.83	3
4	Licensed Practical Nurses	2,843	3,003	78,714	26.21	4
5	CNAs & Orderlies	24,843	25,066	306,711	12.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,788	1,935	24,444	12.63	9
10	Activity Assistants					10
11	Social Service Workers	1,820	1,820	26,700	14.67	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,065	22,526	10.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,540	7,687	70,195	9.13	15
16	Dishwashers					16
17	Maintenance Workers	1,062	1,062	14,639	13.78	17
18	Housekeepers	8,838	9,366	107,445	11.47	18
19	Laundry	680	680	5,613	8.25	19
20	Administrator	1,727	1,879	67,864	36.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,338	1,338	18,663	13.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,884	1,884	54,319	28.83	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,216	68,723	\$ 1,096,247 *	\$ 15.95	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	30	\$ 1,458	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	2,581	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)	30	\$ 22,039		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Linda Houlihan	Administrator	0	\$ 35,588	Workers' Compensation Insurance	\$ 27,297	IDPH License Fee	\$ 1,990	
Jason Stewart	Administrator	0	9,519	Unemployment Compensation Insurance	27,505	Advertising: Employee Recruitment	2,085	
Lori Schalis	Administrator	0	22,757	FICA Taxes	72,527	Health Care Worker Background Check		
				Employee Health Insurance	1,364	(Indicate # of checks performed <u>92</u> )	827	
				Employee Meals	124	Miscellaneous Licenses & Permits	350	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	250	
				Employee Relations	442	Home Office Allocation	1,009	
				Home Office Allocation	17,729			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 67,864					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 225,100				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 225,100				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	40
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V,	
Rochelle Municipal Utilities	Computer Services	\$ 239					line 24, col. 8)	
Honkamp Krueger	Legal Services	2,212						
Comcast	Computer Services	1,095						
E-Health Data Solutions	Computer Services	2,961						
Ogle County Clerk	Filing Fees	55						
TOTAL (agree to Schedule V, line 19, column 3)				\$			TOTAL	
(For legal fee disclosure, see page 39 of instructions)			\$ 6,562				\$ 40	

\* Attach copy of IMRF notifications

\*\*See instructions.

Rochelle Rehab & Hlthcare Cr  
0050856

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,562

Home Office Allocation

Denton's US LLP	Legal	58
Applegate and Thorne	Legal	9
Miller Hall and Triggs	Legal	9
Healthcare Resources International	Legal	47
Lexis Nexis	Legal	3
GoffWilson	Legal	396
Duane Morris LLP	Legal	1709
Miscellaneous	Legal	27
CliftonLarson Allen	Accountants	617
Ginoli & Co.	Accountants	1,226
Miscellaneous	Computer Services	29
CCH	Computer Services	7
PTC Select	Computer Services	9
Advanced Answers on Demand	Computer Services	1266
Stratus Networks	Computer Services	230
Kemper Technology	Computer Services	339
AT&T	Computer Services	3
Ability Network	Computer Services	326
CIAN	Computer Services	229
Comcast	Computer Services	9
Emdeon	Computer Services	19
Charter Communications	Computer Services	16
Allscripts	Computer Services	11
Allpayer Exchange	Computer Services	7
E-Health Technologies	Computer Services	5

Macquarie Technology Services	Computer Services	8
Optimizer	Other Prof Fees	22
D.J. Howard Appraisers	Other Prof Fees	20
Key Corporate Services	Other Prof Fees	67
Consolidated Land Surveying	Other Prof Fees	42
Alan Litwiller	Other Prof Fees	9
Marotta Gund Budd & Derza	Other Prof Fees	18121
Private Bank	Other Prof Fees	959
Total (agree to Schedule V, line 19, column 8)		<u>32,416</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rochelle Rehab & Hlthcare Cr# 0050856

Report Period Beginning:

1/1/2015

Ending:

12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,420 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 86,343  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 124 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 404
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,615
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.