

		FOR BHF USE					

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**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)**

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.

<p>I. IDPH License ID Number: <u>0050617</u></p> <p>Facility Name: <u>Rochelle Gardens Care Center</u></p> <p>Address: <u>1021 Caron Road</u> <u>Rochelle</u> <u>61068</u> <small>Number City Zip Code</small></p> <p>County: <u>Ogle</u></p> <p>Telephone Number: <u>(815) 562-4047</u> Fax # <u>(815) 562-6689</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/31/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;"> Officer or Administrator of Provider </td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:20%; padding: 5px; vertical-align: top;"> Paid Preparer </td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Rochelle Gardens Care Center

0050617 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3	6	Intermediate (ICF)	6	2,190	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,150	245	337	18,732	8
9	SNF/PED					9
10	ICF	2,190			2,190	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,340	245	337	20,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.46%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 68 and days of care provided 337

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	110,292	17,947	466	128,705		128,705	4,697	133,402		1
2	Food Purchase		153,614		153,614		153,614	(559)	153,055		2
3	Housekeeping	102,007	21,015		123,022		123,022	71	123,093		3
4	Laundry	35,553	1,865		37,418		37,418		37,418		4
5	Heat and Other Utilities			73,085	73,085		73,085	(528)	72,557		5
6	Maintenance	31,900	6,049	19,789	57,738		57,738	2,219	59,957		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	279,752	200,490	93,340	573,582		573,582	5,900	579,482		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	781,733	70,022	166,678	1,018,433		1,018,433	(835)	1,017,598		10
10a	Therapy			53,597	53,597		53,597		53,597		10a
11	Activities	66,906	17	362	67,285		67,285	(38,601)	28,684		11
12	Social Services	39,305			39,305		39,305		39,305		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	887,944	70,039	232,637	1,190,620		1,190,620	(39,436)	1,151,184		16
	C. General Administration										
17	Administrative			215,000	215,000		215,000	(146,989)	68,011		17
18	Directors Fees										18
19	Professional Services			6,289	6,289		6,289	27,154	33,443		19
20	Dues, Fees, Subscriptions & Promotions			2,423	2,423		2,423	110	2,533		20
21	Clerical & General Office Expenses	26,176	1,736	13,511	41,423		41,423	50,274	91,697		21
22	Employee Benefits & Payroll Taxes			141,850	141,850		141,850	22,738	164,588		22
23	Inservice Training & Education							140	140		23
24	Travel and Seminar							70	70		24
25	Other Admin. Staff Transportation			11,101	11,101		11,101	3,366	14,467		25
26	Insurance-Prop.Liab.Malpractice			33,918	33,918		33,918	892	34,810		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	26,176	1,736	424,092	452,004		452,004	(42,245)	409,759		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,193,872	272,265	750,069	2,216,206		2,216,206	(75,781)	2,140,425		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.

Facility Name & ID Number Rochelle Gardens Care Center

#0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	
	D. Ownership											
30	Depreciation			80,885	80,885		80,885	5,869	86,754			30
31	Amortization of Pre-Op. & Org.							10,580	10,580			31
32	Interest			54,144	54,144		54,144	18,496	72,640			32
33	Real Estate Taxes			24,036	24,036		24,036	270	24,306			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,384	17,384		17,384	1,427	18,811			35
36	Other (specify):*											36
37	TOTAL Ownership			176,449	176,449		176,449	36,642	213,091			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,488		8,488		8,488		8,488			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,357	165,357		165,357		165,357			42
43	Other (specify):*	26,305		78,148	104,453		104,453	(104,453)				43
44	TOTAL Special Cost Centers	26,305	8,488	243,505	278,298		278,298	(104,453)	173,845			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,220,177	280,753	1,170,023	2,670,953		2,670,953	(143,592)	2,527,361			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(579)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,073)	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	(6,198)	30		9
10	Interest and Other Investment Income	(2,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(71)	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	(24,549)	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	(45,000)	43		24
25	Fund Raising, Advertising and Promotional	(26,873)	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	(42,440)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,802)		\$	30

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	
		Amount	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)	(2,057)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,057)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (155,859)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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Rochelle Gardens Care Center

ID# 0050617

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Offset Miscellaneous Office Supplies Revenue	\$ (277)	21	1
2	Offset Transportation Revenue	(38,601)	11	2
3	Special Events	(584)	43	3
4	Offset Electricity Security Deposit	(775)	5	4
5	Offset Miscellaneous Nursing Supplies	(900)	10	5
6	Labs-Part A	(980)	43	6
7	X-Rays-Part A	(323)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(42,440)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,697	\$ 4,697	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	20	20	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	71	71	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	247	247	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,219	2,219	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	65	65	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	215,000	Petersen Health Care Management, Inc.	100.00%	68,011	(146,989)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	14,709	14,709	12
13	V							13
14	Total		\$ 215,000			\$ 90,039	\$ * (124,961)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 110	\$	110	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	50,551		50,551	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	22,738		22,738	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	140		140	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	70		70	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,366		3,366	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	892		892	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	12,038		12,038	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	108		108	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	391		391	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	270		270	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,427		1,427	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 92,101	\$ *	92,101	39

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

Facility Name & ID Number Rochelle Gardens Care Center# 0050617Report Period Beginning: 1/1/2017Ending: 12/31/2017

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%	6,748	6,748	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		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%	0		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%	369	369	33	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	10,472	10,472	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	13,214	13,214	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		\$			\$ 30,803	\$ *	30,803	39

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

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 Gardens Care Center # 0050617 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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											3
4	N/A										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 Gardens Care Center# 0050617 Report Period Beginning: 1/1/2017Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	1,451,714	75	\$ 325,901	\$ 376,129	20,922	\$ 4,697	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	20,922	20	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	20,922	71	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	20,922	247	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	20,922	2,219	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,922	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	20,922	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	20,922	65	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	20,922	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,922	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	20,922	68,011	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	20,922	14,709	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	20,922	110	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	20,922	50,551	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,451,714	75	1,577,706	0	20,922	22,738	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	20,922	140	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	20,922	70	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	20,922	3,366	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	20,922	892	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	20,922	12,038	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	20,922	108	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	20,922	391	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	20,922	270	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	20,922	1,427	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 182,140	25

Facility Name & ID Number Rochelle Gardens Care Center# 0050617

Report Period Beginning:

1/1/2017Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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)691-8622A. 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.

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	241,133	3	\$	\$	20,922	\$	1
2	2	Food	Resident Days	241,133	3			20,922		2
3	3	Housekeeping	Resident Days	241,133	3			20,922		3
4	4	Laundry	Resident Days	241,133	3			20,922		4
5	5	Utilities	Resident Days	241,133	3			20,922		5
6	6	Maintenance	Resident Days	241,133	3			20,922		6
7	7	Mgmt. Allocation of Benefits	Resident Days	241,133	3			20,922		7
8	10	Nursing and Medical Records	Resident Days	241,133	3			20,922		8
9	15	Mgmt. Allocation of Benefits	Resident Days	241,133	3			20,922		9
10	17	Administrative	Resident Days	241,133	3			20,922		10
11	19	Professional Services	Resident Days	241,133	3	77,776		20,922	6,748	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	241,133	3			20,922		12
13	21	Clerical and General Office	Resident Days	241,133	3			20,922		13
14	22	Employee Benefits & Payroll	Resident Days	241,133	3			20,922		14
15	23	Inservice Training & Education	Resident Days	241,133	3			20,922		15
16	24	Travel and Seminar	Resident Days	241,133	3			20,922		16
17	25	Other Admin. Staff Transport.	Resident Days	241,133	3			20,922		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	241,133	3			20,922		18
19	30	Depreciation	Resident Days	241,133	3	4,252		20,922	369	19
20	31	Amortization	Resident Days	241,133	3	120,699		20,922	10,472	20
21	32	Interest	Resident Days	241,133	3	152,300		20,922	13,214	21
22	33	Real Estate Taxes	Resident Days	241,133	3			20,922		22
23	34	Rent-Facility and Grounds	Resident Days	241,133	3			20,922		23
24	35	Rent-Equipment & Vehicles	Resident Days	241,133	3			20,922		24
25	TOTALS					\$ 355,027	\$		\$ 30,803	25

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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		7	8	9	10						
		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	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 1,102,941	\$ 937,500	12/31/34	Varies	\$ 54,144	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,102,941	\$ 937,500			\$ 54,144	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(2,019)	10						
11									Home Office Allocation-PHN		20,124	11						
12									Home Office Allocation-PHCM		391	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 18,496	14						
15	TOTALS (line 9+line14)						\$ 1,102,941	\$ 937,500			\$ 72,640	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	24,828	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.)		\$	24,072	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(756)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	24,792	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	270	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	24,306	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	23,162	8
	2013	23,595	9
	2014	23,822	10
	2015	24,108	11
	2016	24,072	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rochelle Gardens Care Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0050617

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

Table with 4 columns: (A) Tax Index Number, (B) Property Description, (C) Total Tax, (D) Tax Applicable to Nursing Home. Row 1: 25-19-100-002, Long-Term Care Facility, \$ 24,071.74, \$ 24,071.74. Totals: \$ 24,071.74, \$ 24,071.74.

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

Facility Name & ID Number Rochelle Gardens Care Center

0050617 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,863 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: 11
3. Current Period Amortization: 10,580 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>105,000</u>	<u>2006</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	105,000		\$ 60,000	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74	2006		\$ 1,532,000	\$	30	\$ 51,067	\$ 34,053	\$ 587,270	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Exterior Sign	2007		4,130		15	275	275	1,220	9
10	Draperies	2007		2,537		10	254	254	2,413	10
11	Carpet for Resident Rooms	2007		21,701		15	1,447	1,447	13,746	11
12	Installation of Tile in Main Hall	2007		6,876		15	458	458	4,351	12
13	Landscaping	2007		3,852		15	257	257	2,441	13
14	Sprinkler Installation	2009		10,994		15	732	732	5,490	14
15	Smoke Detectors Replacement	2010		5,325		10	532	532	3,458	15
16	Sprinkler System Repair	2010		9,787		10	978	978	6,357	16
17	Generator Repair	2011		3,177		7	454	454	2,497	17
18	Sprinkler System Repair	2011		22,860		7	3,266	3,266	17,963	18
19	Water Main Repair	2012		25,002		15	1,666	1,666	7,497	19
20	Blacktop Replacement	2012		27,913		15	1,860	1,860	8,370	20
21	Roof Replacement	2013		44,697		25	1,788	1,788	6,258	21
22	Bathroom Wall	2014		13,874		15	925	925	2,313	22
23	Landscaping	2014		5,500		7	786	786	1,965	23
24	Landscaping Surrounding Building	2015		8,311		7	1,188	1,188	1,782	24
25	Water Heater	2017		5,959		7	426	426	426	25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,895			(1,895)		30
31	Building Booked				61,280			(61,280)		31
32	Building Improvement Booked				11,324			(11,324)		32
33										33
34	2017-Home Office Allocation-Building Improvements			9,570			230	230		34
35	2017-Home Office Allocation-Land Improvements			881			57	57		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	TOTAL (lines 4 thru 69)	\$ 1,764,946	\$ 74,499		\$ 68,646	\$ (22,867)	\$ 675,817	70

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

Facility Name & ID Number Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 61,201	\$ 6,268	\$ 5,620	\$ (648)	5-10 yrs.	\$ 33,283	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	270,000					270,000	73
74	Home Office Allocation			11,780	11,780			74
75	TOTALS	\$ 331,201	\$ 6,268	\$ 17,400	\$ 11,132		\$ 303,283	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 E-150 Van	2017	7,082	\$ 118	\$ 708	\$ 590	5	\$ 708	76
77										77
78										78
79										79
80	TOTALS			\$ 7,082	\$ 118	\$ 708	\$ 590		\$ 708	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)	\$ 2,163,229	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,885	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,754	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 979,808	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					88
89	N/A				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 Gardens Care Center

0050617

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 18,811 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Rochelle Gardens Care Center

0050617

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 16,032
Dishwasher	58
Copier	1,294
Home Office Allocation	1,427
	<u>18,811</u>

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

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	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,263	\$ 18,942	\$	1,263	\$ 18,942	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		411	6,161		411	6,161	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,900	28,494		1,900	28,494	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 prescripts				8,488		8,488	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			\$	3,574	\$ 53,597	\$ 8,488	3,574	\$ 62,085	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 Gardens Care Center**# **0050617**Report Period Beginning: **1/1/2017**Ending: **12/31/2017****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2017**

(last day of reporting year)

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	\$ (2,393,596)	\$ (2,393,596)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>116,772</u>)	1,736,062	1,736,062	3
4	Supply Inventory (priced at <u>Cost</u>)	5,883	5,883	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,780	17,780	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	550	550	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (633,321)	\$ (633,321)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	88,431	60,000	13
14	Buildings, at Historical Cost	1,532,000	1,541,570	14
15	Leasehold Improvements, at Historical Cost	183,240	223,376	15
16	Equipment, at Historical Cost	338,283	338,283	16
17	Accumulated Depreciation (book methods)	(1,081,018)	(979,808)	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)	\$ 1,060,936	\$ 1,183,421	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 427,615	\$ 550,100	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 415,472	\$ 415,472	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,331	57,331	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,487	2,487	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,792	24,792	32
33	Accrued Interest Payable	4,734	4,734	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	26,674	26,674	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 531,490	\$ 531,490	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	937,500	937,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 937,500	\$ 937,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,468,990	\$ 1,468,990	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,041,375)	\$ (918,890)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 427,615	\$ 550,100	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (997,102)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	7,750	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (989,352)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(52,023)	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)	\$ (52,023)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,041,375)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rochelle Gardens Care Center

0050617

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,508,630	1
2	Discounts and Allowances for all Levels	(57,698)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,450,932	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,704	6
7	Oxygen	1,569	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 99,273	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	579	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,021	20
21	Other Medical Services	3,307	21
22	Laundry	102	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,153	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,019	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,019	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	38,601	28
28a	<u>Miscellaneous Revenue</u>	1,952	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 40,553	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,618,930	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	573,582	31
32	Health Care	1,190,620	32
33	General Administration	452,004	33
B. Capital Expense			
34	Ownership	176,449	34
C. Ancillary Expense			
35	Special Cost Centers	112,941	35
36	Provider Participation Fee	165,357	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,670,953	40
41	Income before Income Taxes (line 30 minus line 40)**	(52,023)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (52,023)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,203,415	44
45	Private Pay - Net Inpatient Revenue	203,761	45
46	Medicare - Net Inpatient Revenue	43,756	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,450,932	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Gardens Care Center

0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	2,026	2,110	\$ 65,318	\$ 30.96	1
2	Assistant Director of Nursing	379	379	11,548	30.47	2
3	Registered Nurses	7,769	8,076	238,255	29.50	3
4	Licensed Practical Nurses	1,772	1,772	43,716	24.67	4
5	CNAs & Orderlies	29,209	29,292	378,424	12.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,114	2,225	25,168	11.31	9
10	Activity Assistants	1,825	1,825	15,633	8.57	10
11	Social Service Workers	2,080	2,080	39,305	18.90	11
12	Dietician					12
13	Food Service Supervisor	1,457	1,537	28,011	18.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,527	8,604	82,281	9.56	15
16	Dishwashers					16
17	Maintenance Workers	1,684	1,791	31,900	17.81	17
18	Housekeepers	8,925	9,293	102,007	10.98	18
19	Laundry	3,477	3,643	35,553	9.76	19
20	Administrator	2,080	2,080	68,011	32.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,715	1,715	26,176	15.26	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	5,627	5,780	96,882	16.76	33
34	TOTAL (lines 1 - 33)	80,666	82,202	\$ 1,288,188 *	\$ 15.67	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	9	\$ 466	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,499	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	356	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	17	\$ 18,321		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,687	\$ 137,098	L10, C3	50
51	Licensed Practical Nurses	568	18,863	L10, C3	51
52	Certified Nurse Assistants/Aides	221	4,774	L10, C3	52
53	TOTAL (lines 50 - 52)	4,476	\$ 160,735		53

Rochelle Gardens Care Center

0050617

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,200	1,297	35,991	27.75
Psych. Assistant	417	417	8,481	20.34
Transportation	2,244	2,284	26,105	11.43
Marketing	1,766	1,782	26,305	14.76
TOTAL	5,627	5,780	96,882	

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	
Margarita Cornejo	Administrator	0	\$ 17,500	Workers' Compensation Insurance	\$ 25,937	IDPH License Fee	\$	
Georg Svec	Administrator	0	50,511	Unemployment Compensation Insurance	22,802	Advertising: Employee Recruitment	1,052	
				FICA Taxes	91,317	Health Care Worker Background Check		
				Employee Health Insurance	1,287	(Indicate # of checks performed <u>72</u>)	(64)	
				Employee Meals		Miscellaneous Licenses & Permits	483	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	952	
				Employee Relations	507	Home Office Allocation	110	
				Home Office Allocation	22,738			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 68,011					
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			\$ 215,000				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 215,000				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount			\$ 164,588		\$ 2,533
Rochelle Municipal Utilities	Computer Services		\$ 223					
Comcast Cable	Computer Services		1,089					
Ability Network	Computer Services		4,567					
Honkamp Krueger & Co.	Accounting Fees		410					
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 6,289					

* Attach copy of IMRF notifications

**See instructions.

Rochelle Gardens Care Center**0050617****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,289
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	168
Arnstein & Lehr	Legal	1130
SB2	Legal	710
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	180
Smith Amundsen	Legal	70
Healthcare Resources International	Legal	125
Hunziker Law	Legal	1
Lexis Nexis	Legal	7
Baker Tilly Virchow Krause	Legal	630
Secretary of State	Legal	152
Wells Fargo	Legal	296
CliftonLarsonAllen	Accounting	2019
Ginoli & Co.	Accounting	2892
Baker Tilly Virchow Krause	Accounting	126
Wells Fargo	Accounting	824
Miscellaneous	Computer Services	93
Change Healthcare	Computer Services	8
360 Networks	Computer Services	39
Matrix Care	Computer Services	3520
Stratus Networks	Computer Services	420
Kemper Technology	Computer Services	239
AT&T	Computer Services	6
Ability Network	Computer Services	259
CIAN	Computer Services	293
Comcast	Computer Services	16
CCH	Computer Services	14
Charter Communications	Computer Services	29
Allscripts	Computer Services	261
ATS	Computer Services	268
Citrix Systems	Computer Services	25
Optimizer	Other Prof Fees	47
Ankura	Other Prof Fees	758
David Budde	Other Prof Fees	35
Sargent Consulting	Other Prof Fees	10783
Alix Partners	Other Prof Fees	512
Demonica Kemper	Other Prof Fees	31
Brad Barkley	Other Prof Fees	124
MPAC Healthcare	Other Prof Fees	19
Higgs Appraisal	Other Prof Fees	9
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		<u><u>33,443</u></u>

Facility Name & ID Number Rochelle Gardens Care Center# 0050617

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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? Yes
If YES, give association name and amount. IHCA-\$952
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,450 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. \$ 165,357
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 579
- (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. \$ 31,374
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 7,227
- (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. No
Attach invoices and a summary of services for all architect and appraisal fees