FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE C
THAT IS NECESSARY TO ACCOMPLISH THE ST
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. I
OF THIS INFORMATION IS MANDATORY. FAII
ANY INFORMATION ON OR BEFORE THE DUE
RESULT IN CESSATION OF PROGRAM PAYME
HAS BEEN APPROVED BY THE FORMS MANA

I. IDPH License ID Number: 0053017

Facility Name: Rock Falls Rehabilitation & Health Care Center

Address: 430 Martin Road, P.O. Box 579 (Number) Rock Falls (City) 61071 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-4575 **Fax #** (815) 626-8264

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to t
State of Illinois, for the period from 1/1/2018 to
and certify to the best of my knowledge and belief that the said
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than prov
is based on all information of which preparer has any knowledg

Intentional misrepresentation or falsification of any informati
in this cost report may be punishable by fine and/or imprisonme

Officer or Administrator of Provider	(Signed)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMIL
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

)F INFORMATIOI
[ATUTORY
DISCLOSURE
LURE TO PROVIDI
DATE WILI
NTS. THIS FORM
GEMENT CENTER.

the
12/31/2018
contents

vider)
e.

on
nt.

(Date)

(Date)

( )

Y SERVICES

e # (217) 782-1630

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,950	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		640	782	1,422	8
9	SNF/PED					9
10	ICF	8,154			8,154	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,154	640	782	9,576	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed

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)
Independent Living

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

bed days on line 7, column 4.) **46.03%**

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

782

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	104,858	9,420		114,278		114,278	(19,658)	94,620			1
2	Food Purchase		75,390		75,390		75,390	(16,965)	58,425			2
3	Housekeeping	89,119	12,010		101,129		101,129	(19,418)	81,711			3
4	Laundry	204	8,376		8,580		8,580	(1,651)	6,929			4
5	Heat and Other Utilities			91,051	91,051		91,051	(17,397)	73,654			5
6	Maintenance	32,715	6,790	30,075	69,580		69,580	(12,474)	57,106			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	226,896	111,986	121,126	460,008		460,008	(87,563)	372,445			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	410,980	56,683	242,406	710,069		710,069	553	710,622			10
10a	Therapy			79,579	79,579		79,579		79,579			10a
11	Activities	39,083	54	618	39,755		39,755	(10,843)	28,912			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	450,063	56,737	339,403	846,203		846,203	(10,290)	835,913			16
	C. General Administration											
17	Administrative			167,800	167,800		167,800	(95,800)	72,000			17
18	Directors Fees											18
19	Professional Services			3,267	3,267		3,267	14,231	17,498			19
20	Dues, Fees, Subscriptions & Promotions			6,023	6,023		6,023	1,225	7,248			20
21	Clerical & General Office Expenses	28,123	974	11,962	41,059		41,059	23,864	64,923			21
22	Employee Benefits & Payroll Taxes			88,818	88,818		88,818	10,023	98,841			22
23	Inservice Training & Education							58	58			23
24	Travel and Seminar							1	1			24
25	Other Admin. Staff Transportation			7,078	7,078		7,078	1,770	8,848			25
26	Insurance-Prop.Liab.Malpractice			23,561	23,561		23,561	444	24,005			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	28,123	974	308,509	337,606		337,606	(44,184)	293,422			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	705,082	169,697	769,038	1,643,817		1,643,817	(142,037)	1,501,780			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 Rock Falls Rehabilitation & Health Care Center #0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,501	31,501		31,501	(806)	30,695			30
31	Amortization of Pre-Op. & Org.							1,598	1,598			31
32	Interest			69,646	69,646		69,646	18,676	88,322			32
33	Real Estate Taxes			26,303	26,303		26,303	176	26,479			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,635	18,635		18,635	511	19,146			35
36	Other (specify):*											36
37	TOTAL Ownership			146,085	146,085		146,085	20,155	166,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,741		15,741		15,741		15,741			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,147	84,147		84,147		84,147			42
43	Other (specify):* Miscellaneous	27,574	277	36,345	64,196		64,196	(64,196)				43
44	TOTAL Special Cost Centers	27,574	16,018	120,492	164,084		164,084	(64,196)	99,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	732,656	185,715	1,035,615	1,953,986		1,953,986	(186,078)	1,767,908			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 Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,484)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,084)	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	(1,288)	30		9
10	Interest and Other Investment Income	(1,412)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	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	(14,886)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(536)	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	(135,482)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (175,436)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,642)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (10,642)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (186,078)		37

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

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

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

STATE OF ILLINOIS

Rock Falls Rehabilitation & Health Care Center

ID# 0053017

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed Special Events	$ (429)	43	1
2	Offset Transportation Revenue	(10,843)	11	2
3	Offset Marketing Salaries	(27,574)	43	3
4	Disallow Chamber of Commerce Dues	(500)	20	4
5	Independent Living depreciation offset	(5,162)	30	5
6	Independent Living - Dietary	(21,984)	1	6
7	Independent Living - Food	(14,503)	2	7
8	Independent Living - Housekeeping	(19,455)	3	8
9	Independent Living - Laundry	(1,651)	4	9
10	Independent Living - Utilities	(17,516)	5	10
11	Independent Living - Maintenance	(13,386)	6	11
12	Labs-Part A	(173)	43	12
13	X-Rays-Part A	(455)	11	13
14	Offset Miscellaneous Nursing Supplies Revenue	(1,056)	10	14
15	Offset Cable TV Revenue	(795)	43	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	**Total**	(135,482)		49

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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 ENTITIE	
Name	Ownership %	Name	City	Name	City
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. [X] 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 Dif Adjustı Related Costs (7
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 2,326	$
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	22	
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	37	
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	119	
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	912	
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	1,609	
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0	
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
11	V	17	Administrative	81,400	Petersen Health Care Management, Inc.	100.00%	72,000	
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,039	
13	V							
14	Total			$ 81,400			$ 84,064	$ *

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

S Type of Business

ference: nents for Organization minus 4)	
2,326	1
22	2
37	3
119	4
912	5
	6
	7
1,609	8
	9
	10
(9,400)	11
7,039	12
	13
2,664	14

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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. [X] 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 D Adjus Relate Costs (
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 1,725	$
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	23,864	
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,023	
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	58	
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	1	
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,770	
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	444	
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	5,644	
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	51	
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	1,484	
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	176	
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	511	
27	V							
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total			$			$ 45,751	$ *

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

ifference: tments for d Organization (7 minus 4)	
1,725	15
23,864	16
10,023	17
58	18
1	19
1,770	20
444	21
5,644	22
51	23
1,484	24
176	25
511	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36
	37
	38
45,751	39

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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. [X] 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 D Adjus Relate Costs (
15	V	1	Dietary	$	Petersen Health Wellness, LLC	100.00%	$ 0	$
16	V	2	Food		Petersen Health Wellness, LLC	100.00%	0	
17	V	3	Housekeeping		Petersen Health Wellness, LLC	100.00%	0	
18	V	4	Laundry		Petersen Health Wellness, LLC	100.00%	0	
19	V	5	Utilities		Petersen Health Wellness, LLC	100.00%	0	
20	V	6	Maintenance		Petersen Health Wellness, LLC	100.00%	0	
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0	
22	V	10	Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0	
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0	
24	V	17	Administrative	86,400	Petersen Health Wellness, LLC	100.00%	0	
25	V	19	Professional Services		Petersen Health Wellness, LLC	100.00%	7,192	
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0	
27	V	21	Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0	
28	V	22	Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0	
29	V	23	Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0	
30	V	24	Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0	
31	V	25	Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0	
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0	
33	V	30	Depreciation		Petersen Health Wellness, LLC	100.00%	0	
34	V	31	Amortization		Petersen Health Wellness, LLC	100.00%	1,547	
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	18,604	
36	V	33	Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0	
37	V	34	Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0	
38	V	35	Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0	
39	Total			$ 86,400			$ 27,343	$ *

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

ifference: tments for d Organization (7 minus 4)	
	15
	16
	17
	18
	19
	20
	21
	22
	23
(86,400)	24
7,192	25
	26
	27
	28
	29
	30
	31
	32
	33
1,547	34
18,604	35
	36
	37
	38
(59,057)	39

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 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			
2			Vandalia Rehab & Health Care Center	Vandalia			
3			Watseka Health Care Center	Watseka			
4			Westside Rehab & Care Center	West Frankfort			
5			Whispering Oaks	Rosiclare			
6			White Oak Rehab & Health Care Center	Mt. Vernon			
7			Willow Rose Rehab & Health Care Center	Jerseyville			
8			Sheldon Health Care Center	Sheldon			
9			Tuscola Health Care Center	Tuscola			
10			Effingham Health Care Center	Effingham			
11			Collinsville Health Care Center	Collinsville			
12			Ozark Rehab & Health Care Center	Osage Beach, MO			
13			Tarkio Rehab & Health Care Center	Tarkio, MO			
14			Shangri-la Rehab & Living Center	Blue Springs, MO			
15			Prairie Rose Care Center	Pana			
16			Illini Heritage Rehab & Health Center	Champaign			
17			Courtyard Estates of Kewanee	Kewanee			
18			Courtyard Estates of Bradford	Bradford			
19			Courtyard Estates of Galva	Galva			
20			Courtyard Estates of Walcott	Walcott			
21			Courtyard Village of Kewanee	Kewanee			
22			Lakewood Village	Charleston			
23			Courtyard Estates of Monmouth	Monmouth			
24			Riverview Estates	Havana			
25			Simple Blessings	Casey			
26			Courtyard Estates of Bushnell	Bushnell			
27			Courtyard Estates of Canton	Canton			
28			Legacy Estates of Monmouth	Monmouth			
29			Courtyard Estates of Sullivan	Sullivan			
30			Courtyard Estates of Peoria	Peoria			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 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			Cornerstone Health and Rehabilitation	Peoria			
2			Rock River Gardens	Sterling			
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls			
4			Courtyard Estates of Farmington	Farmington			
5			Courtyard Estates of Knoxville	Knoxville			
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Ce # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1	1	Dietary	Resident Days	1,411,762	75	$ 342,871	$ 393,211	9,576	$ 2,326
2	2	Food	Resident Days	1,411,762	75	3,216	0	9,576	22
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	9,576	37
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	9,576	119
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	9,576	912
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	9,576	0
7	9	Medical Director	Resident Days	1,411,762	75	0	0	9,576	0
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	9,576	1,609
9	10A	Therapy	Resident Days	1,411,762	75	0	0	9,576	0
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	9,576	0
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	9,576	72,000
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	9,576	7,039
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	9,576	1,725
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	9,576	23,864
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	9,576	10,023
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	9,576	58
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	9,576	1
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	9,576	1,770
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	9,576	444
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	9,576	5,644
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	9,576	51
22	32	Interest	Resident Days	1,411,762	75	218,814	0	9,576	1,484
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	9,576	176
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	9,576	511
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 129,815

	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1	1	Dietary	Resident Days	105,429	8	$	$	9,576	$
2	2	Food	Resident Days	105,429	8			9,576	
3	3	Housekeeping	Resident Days	105,429	8			9,576	
4	4	Laundry	Resident Days	105,429	8			9,576	
5	5	Utilities	Resident Days	105,429	8			9,576	
6	6	Maintenance	Resident Days	105,429	8			9,576	
7	7	Mgmt. Allocation of Benefits	Resident Days	105,429	8			9,576	
8	10	Nursing and Medical Records	Resident Days	105,429	8			9,576	
9	15	Mgmt. Allocation of Benefits	Resident Days	105,429	8			9,576	
10	17	Administrative	Resident Days	105,429	8			9,576	
11	19	Professional Services	Resident Days	105,429	8	79,186		9,576	7,192
12	20	Dues, Fees, Subs & Promotions	Resident Days	105,429	8			9,576	
13	21	Clerical and General Office	Resident Days	105,429	8			9,576	
14	22	Employee Benefits & Payroll	Resident Days	105,429	8			9,576	
15	23	Inservice Training & Education	Resident Days	105,429	8			9,576	
16	24	Travel and Seminar	Resident Days	105,429	8			9,576	
17	25	Other Admin. Staff Transport.	Resident Days	105,429	8			9,576	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	105,429	8			9,576	
19	30	Depreciation	Resident Days	105,429	8			9,576	
20	31	Amortization	Resident Days	105,429	8	17,031		9,576	1,547
21	32	Interest	Resident Days	105,429	8	204,829		9,576	18,604
22	33	Real Estate Taxes	Resident Days	105,429	8			9,576	
23	34	Rent-Facility and Grounds	Resident Days	105,429	8			9,576	
24	35	Rent-Equipment & Vehicles	Resident Days	105,429	8			9,576	
25	TOTALS					$ 301,046	$		$ 27,343

	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Gemino		X	Mortgage	Varies	7/1/15	$ 1,469,675	$ 1,310,345	6/30/34	Varies	$ 69,646	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,469,675	$ 1,310,345			$ 69,646	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,412)	10
11								Home Office Allocation-PHCM			1,484	11
12								Home Office Allocation-PHW			18,604	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 18,676	14
15	TOTALS (line 9+line14)						$ 1,469,675	$ 1,310,345			$ 88,322	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.)

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,044	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.)		$ 13,385	2
3. Under or (over) accrual (line 2 minus line 1).		$ (14,659)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,962	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.**	**Home Office Allocation** 176 **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 26,479	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	25,796	8
	2014	26,233	9
	2015	26,702	10
	2016	27,229	11
	2017	26,771	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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:

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Falls Rehabilitation & Health Care Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0053017

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-427-006	Long-Term Care Facility	$ 26,771.40	$ 26,771.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$

TOTALS	$ 26,771.40	$ 26,771.40

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 _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,658 B. General Construction Type: Exterior Masonry Frame Masonry Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrela 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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Compl 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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 188,175
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 1,598
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	Facility	49,223	2005	$ 36,375	1
2					2
3	TOTALS	49,223		$ 36,375	3

1

ıted

ɛtely

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
4	57		2005	1972	$ 387,375	$	25	$ 15,495	$ 15,495	$
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks			2006	10,700		15	713	713	
10	Sprinkler Head Installation			2009	6,913		15	460	460	
11	Sidewalks			2011	3,825		15	256	256	
12	Copper Line Installation			2012	4,869		7	696	696	
13	Generator			2012	62,040		15	4,036	4,036	
14	Air Conditoner			2013	3,593		7	513	513	
15	Roofing above Library			2014	27,500		25	1,100	1,100	
16	Dry System Repair			2014	2,861		7	409	409	
17	Air Conditoner			2015	5,738		15	384	384	
18	Pipe Repairs			2015	2,651		7	380	380	
19	Water Pipe Repair			2016	4,558		7	652	652	
20	Water Line Repair			2016	2,955		7	422	422	
21	Sidewalk Replacement			2017	5,000		15	334	334	
22	Air Conditoner			2018	3,875		7	277	277	
23	Air Conditioner Repair			2018	2,917		7	208	208	
24	Air Conditioner Repair			2018	3,442		7	246	246	
25	Water Heater			2018	7,085		7	506	506	
26										
27										
28										
29										
30	Land Improvements Booked					1,768			(1,768)	
31	Building Booked					15,041			(15,041)	
32	Building Improvement Booked					11,033			(11,033)	
33										
34	2018-Home Office Allocation-Building Improvements				4,504			108	108	
35	2018-Home Office Allocation-Land Improvements				452			29	29	
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

9 cumulated epreciation	
154,655	4
	5
	6
	7
	8
8,200	9
3,910	10
1,664	11
3,834	12
22,248	13
2,822	14
4,950	15
1,841	16
1,344	17
1,330	18
1,630	19
1,055	20
501	21
277	22
208	23
246	24
506	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 26,791	$ 3,659	$ 3,471	$ (188)	5-10 yrs.	$ 8,467	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	110,035					110,035	73
74	Home Office Allocation							74
75	TOTALS	$ 136,826	$ 3,659	$ 3,471	$ (188)		$ 118,502	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 726,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,501	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,695	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (806)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 329,723	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	Independent Living (2005)	$ 100,861	$ 4,049	$ 54,663	86
87	Water Heater	3,537		3,537	87
88	Water Line Repair	7,599	540	7,599	88
89					89
90					90
91	TOTALS	$ 111,997	$ 4,589	$ 65,799	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.

**

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreeme
Beginning
Ending

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

	Fiscal Year Ending	Annual Ren
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 19,146 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 atta schedule.

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

ent:

current

t

g,
ched

lease
d.

Rock Falls Rehabilitation & Health Care Center
0053017
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 14,471
Dishwasher	760
Copier	3,404
Home Office Allocation	511
	19,146

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of inco
facility received training CNAs from other

$

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.

ome your
facilities.

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

		1	2	3	4	5	6	7	8
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,155	$ 32,324	$	2,155	$ 32,324
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		931	13,967		931	13,967
3	Licensed Recreational Therapist		hrs						
4	Licensed Physical Therapist	10A(3)	hrs		2,211	33,172		2,211	33,172
5	Physician Care		visits						
6	Dental Care		visits						
7	Work Related Program		hrs						
8	Habilitation		hrs						
9	Pharmacy	39(2)	# of prescrpts				15,741		15,741
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						
11	Academic Education		hrs						
12	Other (specify):								
13	Other (specify): Respiratory Therapy				8	116		8	116
14	TOTAL			$	5,305	$ 79,579	$ 15,741	5,305	$ 95,320

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.

	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (31,548)	$ (31,548)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,416)	973,533	973,533	3
4	Supply Inventory (priced at Cost)	7,395	7,395	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,971	14,971	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,351	$ 964,351	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	47,900	36,375	13
14	Buildings, at Historical Cost	374,625	391,879	14
15	Leasehold Improvements, at Historical Cost	164,728	160,974	15
16	Equipment, at Historical Cost	136,826	136,826	16
17	Accumulated Depreciation (book methods)	(407,730)	(329,723)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	130,377	130,377	21
22	Other Long-Term Independent Living Facility		46,198	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 446,726	$ 572,906	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,411,077	$ 1,537,257	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 356,122	$ 356,122	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,500	13,500	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,471	41,471	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,295	1,295	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,962	40,962	32
33	Accrued Interest Payable	5,924	5,924	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	197,361	197,361	36
37	Accrued Management Fees	107,206	107,206	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 763,841	$ 763,841	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,310,345	1,310,345	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	39	39	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,310,384	$ 1,310,384	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,074,225	$ 2,074,225	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (663,148)	$ (536,968)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,411,077	$ 1,537,257	48

***(See instructions.)**

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (335,972)	1	
2	Restatements (describe):		2	
3	**Rounding**	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (335,971)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(327,177)	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)**	$ (327,177)	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)**	$ (663,148)	24	*

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,409,298	1
2	Discounts and Allowances for all Levels	(93,083)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,316,215	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,031	6
7	Oxygen	1,930	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 169,961	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	2,484	14
15	Telephone, Television and Radio	795	15
16	Rental of Facility Space		16
17	Sale of Drugs	23,650	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,453	20
21	Other Medical Services	17,210	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 45,592	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,412	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,412	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent Living Revenue	81,730	28
28a	Transportation and Miscellaneous Revenue	11,899	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 93,629	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,626,809	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	460,008	31
32	Health Care	846,203	32
33	General Administration	337,606	33
	B. Capital Expense		
34	Ownership	146,085	34
	C. Ancillary Expense		
35	Special Cost Centers	79,937	35
36	Provider Participation Fee	84,147	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,953,986	40
41	**Income before Income Taxes (line 30 minus line 40)****	(327,177)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (327,177)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,077,273	44
45	Private Pay - Net Inpatient Revenue	80,170	45
46	Medicare - Net Inpatient Revenue	154,645	46
47	Other-(specify) Insurance Net Inpatient Revenue	4,127	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,316,215	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.**

STATE OF ILLINOIS

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 63,254	$ 30.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,183	3,219	85,916	26.69	3
4	Licensed Practical Nurses	3,646	3,655	87,352	23.90	4
5	CNAs & Orderlies	10,886	11,129	128,726	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,929	2,031	39,083	19.24	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,281	13.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,321	7,645	76,577	10.02	15
16	Dishwashers					16
17	Maintenance Workers	1,832	1,901	32,715	17.21	17
18	Housekeepers	8,634	8,732	89,119	10.21	18
19	Laundry	20	20	204	10.20	19
20	Administrator	2,080	2,080	72,000	34.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,245	1,309	28,123	21.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,668	3,723	73,306	19.69	33
34	TOTAL (lines 1 - 33)	48,604	49,604	$ 804,656 *	$ 16.22	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period
35	Dietary Consultant		$
36	Medical Director	Monthly	16,800
37	Medical Records Consultant		
38	Nurse Consultant		
39	Pharmacist Consultant	Monthly	2,050
40	Physical Therapy Consultant		
41	Occupational Therapy Consultant		
42	Respiratory Therapy Consultant	16	924
43	Speech Therapy Consultant		
44	Activity Consultant		
45	Social Service Consultant		
46	Other(specify)		
47			
48			
49	TOTAL (lines 35 - 48)	16	$ 19,774

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages
50	Registered Nurses	246	$ 13,193
51	Licensed Practical Nurses	2,485	96,596
52	Certified Nurse Assistants/Aides	6,170	129,643
53	TOTAL (lines 50 - 52)	8,901	$ 239,432

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

**** See instructions.**

3

Schedule V Line & Column Reference	
L1, C3	35
L9,C3	36
	37
	38
L10, C3	39
	40
	41
L10, C3	42
	43
	44
	45
	46
	47
	48
	49

3

Schedule V Line & Column Reference	
L10, C3	50
L10, C3	51
L10, C3	52
	53

Rock Falls Rehabilitation & Health Care Center
0053017
Period Beginning **1/1/2018**
Period End **12/31/2018**

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		1,596	1,651	45,732	27.70
Marketing		2,072	2,072	27,574	13.31
	TOTAL	3,668	3,723	73,306	

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margarita Cornejo	Administrator	0	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 167,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 167,800

C. Professional Services

Vendor/Payee	Type	Amount
Comcast	Computer Services	$ 2,163
Ability Network	Computer Services	1,281
Ludens Potter Melton	Reversal of 2017 Fees	(177)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 3,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,617
Unemployment Compensation Insurance	10,216
FICA Taxes	55,436
Employee Health Insurance	1,979
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	570
Home Office Allocation	10,023
TOTAL (agree to Schedule V, line 22, col.8)	$ 98,841

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 20)	
Patient Background Checks	
Miscellaneous Licenses & Permits	
Miscellaneous Dues & Subscriptions	
Home Office Allocation	
Less: Public Relations Expense	
Non-allowable advertising	(
Yellow page advertising	(
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	
Entertainment Expense	(
(agree to Sch. V, TOTAL line 24, col. 8)	$

**See instructions.

Amount
3,990
600
305
628
500
1,725
(500)
)
)
7,248

Amount
1
)
1

Rock Falls Rehabilitation & Health Care Center
0053017
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		3,267
Home Office Allocation		
Duane Morris	Legal	962
Sedgwick CMS	Legal	85
SB2	Legal	238
Miscellaneous	Legal	71
Christoper P. Ryan	Legal	75
Saul Ewing Arnstein & Lehr	Legal	337
Healthcare Resources International	Legal	50
Winston & Strawn	Legal	811
Lexis Nexis	Legal	3
Pretzel & Stouffer	Legal	12
Gemino	Legal	1285
CliftonLarsonAllen	Accounting	492
Ginoli & Co.	Accounting	175
Duane Morris	Accounting	29
Getzler Henrich & Associates	Accounting	378
Kemper Consulting	Accounting	29
Baker Tilly Virchow Krause	Accounting	199
Ginoli & Co.	Accounting	1553
Gemino	Accounting	1960
Miscellaneous	Computer Services	45
Change Healthcare	Computer Services	2
TR Professional	Computer Services	5

Matrix Care	Computer Services	553
Ability Network	Computer Services	875
Stratus Networks	Computer Services	214
Kemper Technology	Computer Services	246
AT&T	Computer Services	3
Ungerboeck Software	Computer Services	177
CIAN	Computer Services	77
Comcast	Computer Services	19
CCH	Computer Services	7
Charter Communications	Computer Services	13
Allscripts	Computer Services	249
ATS	Computer Services	116
Citrix Systems	Computer Services	40
Optimizer	Other Prof Fees	22
Sedgwick CLMS	Other Prof Fees	78
David Budde	Other Prof Fees	22
Sargent Consulting	Other Prof Fees	61
Alix Partners	Other Prof Fees	232
Getzler Henrich & Associates	Other Prof Fees	32
Sargent Consulting	Other Prof Fees	216
Alix Partners	Other Prof Fees	2183
Total (agree to Schedule V, line 19, column 8)		17,498

Rock Falls Rehabilitation & Health Care Center
0053017
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	2,342
Auto Repairs		762
Travel-Mileage		3,974
Home Office Allocation		1,770
		8,848

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0053017 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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-**

(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. $ **10,959** 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. $ **84,147**
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. $ **2,484**

(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. $ **10,843**
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Rock Falls Rehabilitation & Health Care Center
0053017
Period Beginning **1/1/2018**
Period End **12/31/2018**

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**
Independent Living	2,281	19.24%
Nursing Home	9,576	80.76%
	11,857	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	114,278	19.24%	21,984	Census	1
Food	75,390	19.24%	14,503	Census	2
Housekeeping	101,129	19.24%	19,455	Census	3
Laundry	8,580	19.24%	1,651	Census	4
Utilities	91,051	19.24%	17,516	Census	5
Maintenance	69,580	19.24%	13,386	Census	6
Depreciation (Building)	5,162	100.00%	5,162	Beds	30
Total	465,170		93,656		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
Independent Living overhead and depreciation costs have been offset on P5A.