

		FOR BHF USE					

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**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0056473</u></p> <p><b>Facility Name:</b> <u>Rosiclare Rehab HCC</u></p> <p><b>Address:</b> <u>55 Ferrell Rd Bx 220</u> <u>Rosiclare</u> <u>62982</u>  Number City Zip Code</p> <p><b>County:</b> <u>Hardin</u></p> <p><b>Telephone Number:</b> <u>(618) 285-3655</u> Fax # <u>(618) 285-6667</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/1/2005</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <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%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: 1px solid black; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="border: 1px solid black; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  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 Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<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 Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Rosiclare Rehab HCC

# 0056473 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,852	1,961	1,451	13,264	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,852	1,961	1,451	13,264	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 58.61%

**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 10/1/2005

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 62 and days of care provided 1,389

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Rosiclare Rehab HCC # 0056473 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	107,568	12,549		120,117		120,117	3,532	123,649		1
2	Food Purchase		96,560		96,560		96,560	(3,747)	92,813		2
3	Housekeeping	81,448	22,529		103,977		103,977	68	104,045		3
4	Laundry	18,597	7,120		25,717		25,717		25,717		4
5	Heat and Other Utilities			51,403	51,403		51,403	(290)	51,113		5
6	Maintenance	30,691	3,947	26,383	61,021		61,021	2,121	63,142		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	238,304	142,705	77,786	458,795		458,795	1,684	460,479		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	841,291	59,284	4,129	904,704		904,704	(11,181)	893,523		10
10a	Therapy			549,201	549,201		549,201		549,201		10a
11	Activities	50,607	337		50,944		50,944	(812)	50,132		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	891,898	59,621	558,130	1,509,649		1,509,649	(11,993)	1,497,656		16
	<b>C. General Administration</b>										
17	Administrative	78,000		155,700	233,700		233,700	(136,059)	97,641		17
18	Directors Fees										18
19	Professional Services			7,695	7,695		7,695	13,979	21,674		19
20	Dues, Fees, Subscriptions & Promotions			3,058	3,058		3,058	1,808	4,866		20
21	Clerical & General Office Expenses	28,382	1,860	9,867	40,109		40,109	21,844	61,953		21
22	Employee Benefits & Payroll Taxes			138,273	138,273		138,273	6,012	144,285		22
23	Inservice Training & Education							36	36		23
24	Travel and Seminar							11	11		24
25	Other Admin. Staff Transportation			5,455	5,455		5,455	2,530	7,985		25
26	Insurance-Prop.Liab.Malpractice			31,467	31,467		31,467	386	31,853		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	106,382	1,860	351,515	459,757		459,757	(89,453)	370,304		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,236,584	204,186	987,431	2,428,201		2,428,201	(99,762)	2,328,439		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 &amp; ID Number

Rosiclare Rehab HCC

#0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			501	501		501	85,391	85,892			30
31	Amortization of Pre-Op. & Org.							47,713	47,713			31
32	Interest			20,778	20,778		20,778	263,303	284,081			32
33	Real Estate Taxes			5,198	5,198		5,198	139	5,337			33
34	Rent-Facility & Grounds			126,738	126,738		126,738	(126,738)				34
35	Rent-Equipment & Vehicles			21,106	21,106		21,106	1,282	22,388			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			174,321	174,321		174,321	271,090	445,411			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,752		32,752		32,752		32,752			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,265	105,265		105,265		105,265			42
43	Other (specify):*			81,468	81,468		81,468	(81,468)				43
44	<b>TOTAL Special Cost Centers</b>		32,752	186,733	219,485		219,485	(81,468)	138,017			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,236,584	236,938	1,348,485	2,822,007		2,822,007	89,860	2,911,867			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 Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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	(3,747)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,219)	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	(186)	30		9
10	Interest and Other Investment Income	(2,532)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(388)	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	(13,090)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,000)	43		24
25	Fund Raising, Advertising and Promotional	(525)	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	(22,934)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (103,821)		\$	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)	193,681	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 193,681		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 89,860		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

Rosiclare Rehab HCC

ID# 0056473

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (7,184)	43	1
2	X-Rays-Part A	255	43	2
3	Offset Transportation Revenue	(812)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(55)	21	4
5	Disallowed Special Events	15	43	5
6	Disallowed Resident Flowers	(125)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(14,490)	10	7
8	Offset Electric Security Deposit Refund	(531)	5	8
9	Pet Expesne	(7)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	<b>Total</b>	(22,934)		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%	\$ 3,532	\$ 3,532	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	68	68	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	241	241	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,121	2,121	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%	3,309	3,309	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	155,700	Petersen Health Care Management, Inc.	100.00%	19,641	(136,059)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	11,602	11,602	12
13	V							13
14	Total		\$ 155,700			\$ 40,514	\$ * (115,186)	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%	\$ 1,808	\$	1,808	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	21,899		21,899	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	6,012		6,012	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	36		36	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	11		11	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,530		2,530	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	386		386	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	3,575		3,575	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	174		174	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	139		139	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,282		1,282	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 37,852	\$ *	37,852	39

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



Facility Name &amp; ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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 Business, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Business, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Business, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Business, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%			22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			23
24	V	17 Administrative		Petersen Health Business, LLC	100.00%			24
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	2,377	2,377	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%			26
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%			27
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%			32
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%			33
34	V	31 Amortization		Petersen Health Business, LLC	100.00%			34
35	V	32 Interest		Petersen Health Business, LLC	100.00%	6,735	6,735	35
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%			38
39	Total		\$			\$ 9,112	\$ * 9,112	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance	\$	Rosiclare Land, LLC	100.00%	\$	\$	15
16	V	19 Professional Services	\$	Rosiclare Land, LLC	100.00%			16
17	V	21 Equipment		Rosiclare Land, LLC	100.00%			17
18	V	26 Insurance-Property		Rosiclare Land, LLC	100.00%			18
19	V	26 Insurance-Mortgage Insurance		Rosiclare Land, LLC	100.00%			19
20	V	30 Depreciation		Rosiclare Land, LLC	100.00%	82,002	82,002	20
21	V	31 Amortization		Rosiclare Land, LLC	100.00%	47,713	47,713	21
22	V	32 Interest		Rosiclare Land, LLC	100.00%	258,926	258,926	22
23	V	33 Real Estate Taxes		Rosiclare Land, LLC	100.00%			23
24	V	34 Rent-Income and Grounds	126,738	Rosiclare Land, LLC	100.00%		(126,738)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 126,738			\$ 388,641	\$ * 261,903	39

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

Facility Name &amp; ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name &amp; ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## VII. RELATED PARTIES

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

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

Facility Name &amp; ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosiclare Rehab HCC # 0056473 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	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	1,282,791	75	\$ 341,562	\$ 398,718	13,264	\$ 3,532	1
2	2	Food	Resident Days	1,282,791	75	0	0	13,264	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	13,264	68	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	13,264	241	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	13,264	2,121	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	13,264	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	13,264	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	13,264	3,309	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	13,264	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	13,264	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	13,264	19,641	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	13,264	11,602	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	13,264	1,808	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	13,264	21,899	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	13,264	6,012	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	13,264	36	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	13,264	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	13,264	2,530	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	13,264	386	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	13,264	3,575	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	13,264	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	13,264	174	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	13,264	139	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	13,264	1,282	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 78,366	25



Facility Name & ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization Petersen Health Business, 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	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	70,323	9	\$	\$	7,655	\$	1
2	2	Food	Resident Days	70,323	9			7,655		2
3	3	Housekeeping	Resident Days	70,323	9			7,655		3
4	4	Laundry	Resident Days	70,323	9			7,655		4
5	5	Utilities	Resident Days	70,323	9			7,655		5
6	6	Maintenance	Resident Days	70,323	9			7,655		6
7	7	Mgmt. Allocation of Benefits	Resident Days	70,323	9			7,655		7
8	10	Nursing and Medical Records	Resident Days	70,323	9			7,655		8
9	15	Mgmt. Allocation of Benefits	Resident Days	70,323	9			7,655		9
10	17	Administrative	Resident Days	70,323	9			7,655		10
11	19	Professional Services	Resident Days	70,323	9	21,833		7,655	2,377	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	70,323	9			7,655		12
13	21	Clerical and General Office	Resident Days	70,323	9			7,655		13
14	22	Employee Benefits & Payroll	Resident Days	70,323	9			7,655		14
15	23	Inservice Training & Education	Resident Days	70,323	9			7,655		15
16	24	Travel and Seminar	Resident Days	70,323	9			7,655		16
17	25	Other Admin. Staff Transport.	Resident Days	70,323	9			7,655		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	70,323	9			7,655		18
19	30	Depreciation	Resident Days	70,323	9			7,655		19
20	31	Amortization	Resident Days	70,323	9			7,655		20
21	32	Interest	Resident Days	70,323	9	61,870		7,655	6,735	21
22	33	Real Estate Taxes	Resident Days	70,323	9			7,655		22
23	34	Rent-Facility and Grounds	Resident Days	70,323	9			7,655		23
24	35	Rent-Equipment & Vehicles	Resident Days	70,323	9			7,655		24
25	TOTALS					\$ 83,703	\$		\$ 9,112	25

Facility Name & ID Number

Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Bank Leumi		X	Mortgage	Varies	1/1/15	\$ 1,865,868	\$ Paid			\$ 20,778	1						
2	Sector		X	Mortgage	Varies	4/1/2020	2,540,956	2,540,956	3/31/23	Varies	258,926	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 4,406,824	\$ 2,540,956			\$ 279,704	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(2,532)	10						
11									Home Office Allocation-PHCM		174	11						
12									Home Office Allocation-PHB		6,735	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 4,377	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,406,824	\$ 2,540,956			\$ 284,081	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 2019 report.		\$	<b>5,700</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>5,366</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(334)</b>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>5,532</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<b>139</b>	
<b>TOTAL REFUND</b> \$ _____ <b>For</b> _____ <b>Tax Year.</b> <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>5,337</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	<b>5,684</b>	8
	2016	<b>5,780</b>	9
	2017	<b>5,669</b>	10
	2018	<b>5,529</b>	11
	2019	<b>5,366</b>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Rosiclare Rehabilitation & Health Care Center COUNTY Hardin

FACILITY IDPH LICENSE NUMBER 0053512

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-82-001-02-000</u>	<u>Long-Term Care Facility</u>	\$ <u>5,366.28</u>	\$ <u>5,366.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>5,366.28</u></u>	\$ <u><u>5,366.28</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 12,600 B. General Construction Type: Exterior Masonry Frame Metal 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: 127,233 2. Number of Years Over Which it is Being Amortized: 3  
3. Current Period Amortization: 47,713 4. Dates Incurred: 2020

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>304,920</u>	<u>2005</u>	<u>\$ 74,250</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>304,920</b>		<b>\$ 74,250</b>	<b>3</b>

**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	62	2005	1975	\$ 1,430,667	\$	25	\$ 58,227	\$ 58,227	\$ 820,264	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Heat Pump-5-Ton		2008	4,940		5			4,940	9
10	Sprinkler System Repair		2008	32,900		39	844	844	10,268	10
11	Dry Pendant Installation (23)		2008	2,812		20	140	140	1,750	11
12	Sprinkler System Repair		2009	16,205		7			16,205	12
13	Nurse Call System		2010	7,905		10	790	790	7,505	13
14	Sewer Repair		2013	3,090		7	223	223	3,090	14
15	Roof Replacement-Rear and Side Sections of Facility		2014	68,617		25	2,744	2,744	17,836	15
16	Windows (41)		2014	12,683		25	507	507	3,296	16
17	Roof Replacement for Front Section and Dining Room		2014	35,980		25	1,440	1,440	7,560	17
18	Relocation of Streetlight Pole		2015	7,722		15	516	516	2,838	18
19	Roof Replacement for West Section and Kitchen		2019	91,500		25	3,660	3,660	5,490	19
20	Air Conditioner		2019	6,000		15	400	400	600	20
21	Water Heaters		2019	14,875		7	2,126	2,126	3,189	21
22	Water Heaters		2020	8,877		7	634	634	634	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,403			(1,403)		30
31	Building Booked				53,927			(53,927)		31
32	Building Improvement Booked				14,600			(14,600)		32
33										33
34	2020-Home Office Allocation-Building Improvements			6,706			161	161		34
35	2020-Home Office Allocation-Land Improvements			673			43	43		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

Facility Name & ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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)	\$ 1,752,152	\$ 69,930		\$ 72,455	\$ 2,525	\$ 905,465	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 89,289	\$ 12,074	\$ 9,539	\$ (2,535)	5-10 yrs.	\$ 9,539	71
72	Current Year Purchases	7,376	501	527	26	7 yrs.	527	72
73	Fully Depreciated Assets	271,722					271,722	73
74	Home Office Allocation			3,371	3,371			74
75	TOTALS	\$ 368,387	\$ 12,575	\$ 13,437	\$ 862		\$ 281,788	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)	\$ 2,194,789	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,892	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,187,253	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



Facility Name & ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 22,388

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	<b>TOTAL</b>		\$	\$	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.

**Rosiclare Rehab HCC**

**0056473**

**Period Beginning** 1/1/2020

**Period End** 12/31/2020

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 15,183
Dishwasher	701
Copier	5,222
Home Office Allocation	1,282
	<u>22,388</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	\$	14,592	\$ 218,876	\$	14,592	\$ 218,876	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		9,743	146,139		9,743	146,139	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,279	184,186		12,279	184,186	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				32,752		32,752	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	36,614	\$ 549,201	\$ 32,752	36,614	\$ 581,953	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 Rosiclare Rehab HCC

# 0056473

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (55,931)	\$ (55,931)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,492 )	1,637,450	1,637,450	3
4	Supply Inventory (priced at Cost )	8,794	8,794	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,638	15,638	6
7	Other Prepaid Expenses	572	4,105	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,606,523	\$ 1,610,056	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,250	13
14	Buildings, at Historical Cost		1,437,373	14
15	Leasehold Improvements, at Historical Cost		314,779	15
16	Equipment, at Historical Cost	7,376	368,387	16
17	Accumulated Depreciation (book methods)	(501)	(1,187,253)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		79,520	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	19,149	213,877	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	491,279	464,491	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 517,303	\$ 1,765,424	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,123,826	\$ 3,375,480	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,042,899	\$ 1,042,899	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,864	81,864	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,532	5,532	32
33	Accrued Interest Payable		30,472	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	61,097	61,097	36
37	<u>Accrued Management Fees</u>	8,839	8,839	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,200,231	\$ 1,230,703	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,540,956	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Loan Payable-MCAD Adv. &amp; SBA PPP</u>	245,000	245,000	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 245,000	\$ 2,785,956	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,445,231	\$ 4,016,659	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 678,595	\$ (641,179)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,123,826	\$ 3,375,480	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (965,606)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	810,071	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (155,535)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	834,130	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)	\$ 834,130	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 678,595	24 *

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

Facility Name &amp; ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,540,833	1
2	Discounts and Allowances for all Levels	(371,416)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,169,417	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	934,624	6
7	Oxygen	2,759	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 937,383	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,747	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(40,199)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,034	20
21	Other Medical Services	16,566	21
22	Laundry	40	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ (10,812)	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,532	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,532	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	812	28
28a	<u>Miscellaneous Revenue</u>	556,805	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 557,617	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,656,137	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	458,795	31
32	Health Care	1,509,649	32
33	General Administration	459,757	33
<b>B. Capital Expense</b>			
34	Ownership	174,321	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	114,220	35
36	Provider Participation Fee	105,265	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,822,007	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	834,130	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 834,130	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,549,805	44
45	Private Pay - Net Inpatient Revenue	320,346	45
46	Medicare - Net Inpatient Revenue	286,929	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	12,337	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,169,417	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,609	1,749	\$ 63,523	\$ 36.32	1
2	Assistant Director of Nursing	2,775	2,794	76,215	27.28	2
3	Registered Nurses	3,386	3,401	97,907	28.79	3
4	Licensed Practical Nurses	9,253	9,588	190,268	19.84	4
5	CNAs & Orderlies	28,412	29,338	390,107	13.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	27,138	13.05	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,348	16.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,035	7,267	74,220	10.21	15
16	Dishwashers					16
17	Maintenance Workers	1,803	1,851	30,691	16.58	17
18	Housekeepers	7,699	7,969	81,448	10.22	18
19	Laundry	1,541	1,589	18,597	11.70	19
20	Administrator	2,056	2,179	78,000	35.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,900	1,980	28,382	14.33	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>Page 20A</u>	2,815	2,912	46,740	16.05	33
34	TOTAL (lines 1 - 33)	74,444	76,777	\$ 1,236,584 *	\$ 16.11	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 4,800	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,931	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	2 116	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	2 \$ 8,847		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	4 82	L10,C3	52
53	TOTAL (lines 50 - 52)	4 \$ 82		53



Rosiclare Rehab HCC

0056473

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	815	832	23,271	27.97
Transportation	2,000	2,080	23,469	11.28
<b>TOTAL</b>	<b>2,815</b>	<b>2,912</b>	<b>46,740</b>	



**Rosiclare Rehab HCC**

0056473

Period Beginning

1/1/2020

Period End

12/31/2020

**Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,695

**Home Office Allocation**

Baker Tilly Virchow Krause LLP	Legal	204
Duane Morris	Legal	285
Lexis Nexis	Legal	6
Livingston, Barger, Brant, Schroeder	Legal	11
Miller, Hall, Triggs	Legal	35
Miscellaneous	Legal	13
SB2	Legal	105
SmithAmundsen LLC	Legal	653
Sorling Northrup	Legal	186
Sector Bank	Legal	1,826
CliftonLarsonAllen	Accounting	811
Ginoli & Co.	Accounting	1,130
Ability Network	Computer Services	2,082
Allscripts	Computer Services	329
AOD Matrix Care	Computer Services	3,657
AT&T	Computer Services	4
ATS	Computer Services	199
CCH	Computer Services	12
Charter Communications	Computer Services	18
Citrix Systems	Computer Services	62
Comcast	Computer Services	21
ITSavvy	Computer Services	96
Kemper Technology	Computer Services	475
Miscellaneous	Computer Services	92
Pearl Technology	Computer Services	86
Stratus Networks	Computer Services	378
TR Professional	Computer Services	8
David Budde	Other Prof Fees	8
DJ Howard and Associates	Other Prof Fees	16
Getzler Henrich & Associates	Other Prof Fees	64
LRI Consulting Services	Other Prof Fees	63
McQuellon Consulting	Other Prof Fees	40
Miscellaneous	Other Prof Fees	75
Optimizer	Other Prof Fees	34
Registered Agent Solutions	Other Prof Fees	19
RSM McGladrey	Other Prof Fees	207
SB2	Other Prof Fees	264
Sedgwick CMS	Other Prof Fees	356
Tarver Program Consultants	Other Prof Fees	49

Total (agree to Schedule V, line 19, column 8)

21,674

**Rosiclare Rehab HCC**

**0056473**

**Period Beginning** 1/1/2020

**Period End** 12/31/2020

**Schedule 21B**

**25. Administrative and Staff Transportation**

Gas	\$ 4,722
Auto Repairs	733
Mileage-Travel	-
Home Office Allocation	<u>2,530</u>
	<u><u>7,985</u></u>

Facility Name &amp; ID Number Rosiclare Rehab HCC

# 0056473

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (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. \$ 15,244 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. \$ 105,265  
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. \$ 3,747
- (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. \$ 812  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 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.