

		FOR BHF USE					

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**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)**

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

I. IDPH License ID Number: 0047530

Facility Name: Rock Falls Rehabilitation & Health Care Center

Address: 430 Martin Road Rock Falls 61071
Number City Zip Code

County: Whiteside

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

HFS ID Number: _____

Date of Initial License for Current Owners: 10/01/05

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Mark B. 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>	

**MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630**

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center

0047530 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	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				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,441	1,418		9,859	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,441	1,418		9,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.39%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 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 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	116,366	9,085		125,451		125,451	(40,203)	85,248		1
2	Food Purchase		79,299		79,299		79,299	(32,676)	46,623		2
3	Housekeeping	77,909	14,130		92,039		92,039	(30,820)	61,219		3
4	Laundry	26,426	11,805		38,231		38,231	(12,811)	25,420		4
5	Heat and Other Utilities			77,031	77,031		77,031	(25,630)	51,401		5
6	Maintenance	39,935	17,282	21,317	78,534		78,534	(25,248)	53,286		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							430	430		7
8	TOTAL General Services	260,636	131,601	98,348	490,585		490,585	(166,958)	323,627		8
	B. Health Care and Programs										
9	Medical Director			12,200	12,200		12,200		12,200		9
10	Nursing and Medical Records	519,928	24,497	7,641	552,066		552,066	28	552,094		10
10a	Therapy										10a
11	Activities	20,704	341	266	21,311		21,311		21,311		11
12	Social Services	21,646			21,646		21,646		21,646		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	TOTAL Health Care and Programs	562,278	24,838	20,107	607,223		607,223	28	607,251		16
	C. General Administration										
17	Administrative			140,000	140,000		140,000	(71,797)	68,203		17
18	Directors Fees										18
19	Professional Services			2,700	2,700		2,700	2,469	5,169		19
20	Dues, Fees, Subscriptions & Promotions			4,689	4,689		4,689	571	5,260		20
21	Clerical & General Office Expenses	27,974	2,789	5,146	35,909		35,909	18,961	54,870		21
22	Employee Benefits & Payroll Taxes			243,902	243,902		243,902	1,590	245,492		22
23	Inservice Training & Education			389	389		389	131	520		23
24	Travel and Seminar							15	15		24
25	Other Admin. Staff Transportation			3,630	3,630		3,630	1,645	5,275		25
26	Insurance-Prop.Liab.Malpractice			30,765	30,765		30,765	273	31,038		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,459	7,459		27
28	TOTAL General Administration	27,974	2,789	431,221	461,984		461,984	(38,683)	423,301		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	850,888	159,228	549,676	1,559,792		1,559,792	(205,613)	1,354,179		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 #0047530 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			33,594	33,594		33,594	215	33,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,299	41,299		41,299	12,369	53,668			32
33	Real Estate Taxes			26,928	26,928		26,928	(707)	26,221			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,787	11,787		11,787	252	12,039			35
36	Other (specify):*											36
37	TOTAL Ownership			113,608	113,608		113,608	12,129	125,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):* Non-allowable Cost		681	7,364	8,045		8,045	(8,045)				43
44	TOTAL Special Cost Centers		681	38,572	39,253		39,253	(8,045)	31,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	850,888	159,909	701,856	1,712,653		1,712,653	(201,529)	1,511,124			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,103)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,968)	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	1,663	30		9
10	Interest and Other Investment Income	(831)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(382)	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				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	(500)	43		24
25	Fund Raising, Advertising and Promotional	(2,431)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(170,663)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,215)		\$	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)	(18,314)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (18,314)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (201,529)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY

48		49		50		51		52	
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Rock Falls Rehabilitation & Health Care Center

ID# 0047530

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	(764)	43	1
2	Disallow Real Estate Tax penalty	(968)	33	2
3	Offset Miscellaneous Office Supplies Revenue	(136)	21	3
4	Disallow Chamber of Commerce Dues	(351)	20	4
5	Independent Living depreciation offset	(4,049)	30	5
6	Independent Living - Dietary	(42,039)	1	6
7	Independent Living - Food	(26,573)	2	7
8	Independent Living - Housekeeping	(30,842)	3	8
9	Independent Living - Laundry	(12,811)	4	9
10	Independent Living - Utilities	(25,813)	5	10
11	Independent Living - Maintenance	(26,317)	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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31				31
32				32
33				33
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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	(170,663)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 Attached Schedule 6E		See Attached Sch. 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,836	\$ 1,836	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	183	183	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,069	1,069	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	430	430	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	28	28	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	140,000	Petersen Health Care, Inc.	100.00%	68,203	(71,797)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,035	2,035	12
13	V							13
14	Total		\$ 140,000			\$ 73,806	\$ * (66,194)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 504	\$	504	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,278		18,278	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	131		131	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	15		15	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,645		1,645	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	273		273	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,459		7,459	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,115		2,115	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,438		2,438	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	261		261	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	252		252	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		\$			\$ 33,371	\$ *	33,371	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	434	434	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	418	418	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	819	819	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	1,590	1,590	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	486	486	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	10,762	10,762	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total		\$			\$ 14,509	\$ *	14,509

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Ce # 0047530 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	Mark Petersen	President	Administrative	100.00	180,997	0.38	0.63	Salary	\$ 1,253	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,253		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# 0047530

Report Period Beginning:

1/1/2010Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	9,859	\$ 1,836	1
2	2	Food	Resident Days	1,527,029	77	0	0	9,859	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	9,859	22	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	9,859	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	9,859	183	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	9,859	1,069	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	9,859	430	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	9,859	28	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	9,859	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	9,859	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	9,859	68,203	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	9,859	2,035	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	9,859	504	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	9,859	18,278	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	9,859	131	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	9,859	15	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	9,859	1,645	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	9,859	273	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	9,859	7,459	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	9,859	2,115	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	9,859	2,438	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	9,859	261	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	9,859	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	9,859	252	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 107,177	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	389,552	21	\$	\$ 9,859	\$	1
2	2	Food	Resident Days	389,552	21		9,859		2
3	3	Housekeeping	Resident Days	389,552	21		9,859		3
4	4	Laundry	Resident Days	389,552	21		9,859		4
5	5	Utilities	Resident Days	389,552	21		9,859		5
6	6	Maintenance	Resident Days	389,552	21		9,859		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21		9,859		7
8	10	Nursing and Medical Records	Resident Days	389,552	21		9,859		8
9	12	Social Services	Resident Days	389,552	21		9,859		9
10	17	Administrative	Resident Days	389,552	21		9,859		10
11	19	Professional Services	Resident Days	389,552	21	17,164	9,859	434	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534	9,859	418	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356	9,859	819	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830	9,859	1,590	14
15	23	Inservice Training & Education	Resident Days	389,552	21		9,859		15
16	24	Travel and Seminar	Resident Days	389,552	21		9,859		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21		9,859		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21		9,859		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21		9,859		19
20	30	Depreciation	Resident Days	389,552	21	19,207	9,859	486	20
21	32	Interest	Resident Days	389,552	21	425,239	9,859	10,762	21
22	33	Real Estate Taxes	Resident Days	389,552	21		9,859		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21		9,859		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21		9,859		24
25	TOTALS					\$ 573,330	\$	\$ 14,509	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 850,000	\$ 815,004	12/31/13	Varies	\$ 41,299	1							
2												2							
3							Interest Income Offset				(831)	3							
4							Home Office Allocation-PHC				2,438	4							
5							Home Office Allocation-PHO				10,762	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 850,000	\$ 815,004			\$ 53,668	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 850,000	\$ 815,004			\$ 53,668	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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 2009 report.			\$ 26,000	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.)	2009		\$ 25,560	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ (440)	3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 26,400	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	261	6
			\$		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 26,221	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>25,439</u>	8		
	2006	<u>25,640</u>	9		
	2007	<u>24,949</u>	10		
	2008	<u>25,233</u>	11		
	2009	<u>25,560</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Falls Rehabilitation & Health Care Center COUNTY Whiteside
 FACILITY IDPH LICENSE NUMBER 0047530
 CONTACT PERSON REGARDING THIS REPORT Mark Petersen
 TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>11-27-427-006</u>	<u>Long-Term Care Facility</u>	\$ <u>25,559.70</u>	\$ <u>25,559.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>25,559.70</u></u>	\$ <u><u>25,559.70</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 12,658 B. General Construction Type: Exterior Masonry Frame Masonry 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>49,223</u>	<u>2005</u>	<u>\$ 21,375</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	49,223		\$ 21,375	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	57	2005	1972	\$ 273,764	\$	25	\$ 10,951	\$ 10,951	\$ 60,229	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land		2005	12,000		15	800	800	4,400	9
10	Sidewalks		2006	10,700		15	713	713	3,209	10
11	Sprinkler		2006	1,071		25	43	43	193	11
12	Tile Floor		2006	1,916		20	96	96	432	12
13	Gutters		2007	3,166		20	158	158	553	13
14	Lighting		2007	1,352		15	90	90	315	14
15	Sprinkler Head Installation		2009	6,913		15	460	460	690	15
16	Water Heater		2009	3,537		5	707	707	884	16
17	Water Line Repair		2010	7,599		7	543	543	543	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	Land Improvements Booked				1,513			(1,513)		30
31	Building Booked				15,041			(15,041)		31
32	Building Improvement Booked				2,102			(2,102)		32
33										33
34	2010-Home Office Allocation-Building Improvements			4,739			114	114		34
35	2010-Home Office Allocation-Land Improvements			442			25	25		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$	\$ 327,199		\$ 14,700	\$ (3,956)	\$ 71,448	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 110,036	\$ 14,938	\$ 16,647	\$ 1,709	7-10 yrs.	\$ 85,740	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,462	2,462			74
75	TOTALS	\$ 110,036	\$ 14,938	\$ 19,109	\$ 4,171		\$ 85,740	75

D. Vehicle Depreciation (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)	\$ 458,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,594	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,809	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 215	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 157,188	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	\$ 22,271	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 100,861	\$ 4,049	\$ 22,271	91

G. Construction-in-Progress

	Description	Cost	
92	N/A		92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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: _____ *

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: \$ 5,101 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250 Van	\$ 578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	21

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning **1/1/2010**
Period End **12/31/2010**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	376
Dishwasher		708
Copier		3,765
Home Office Allocation		252
		<u>5,101</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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation	N/A	hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): _____									12	
13	Other (specify): _____									13	
14	TOTAL			\$		\$	\$		\$	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 **Rock Falls Rehabilitation & Health Care Center**

0047530

Report Period Beginning: **1/1/2010**

Ending: **12/31/2010**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010** (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	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>15,000</u>)	68,662	68,662	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,851	20,851	6
7	Other Prepaid Expenses	7,395	7,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Management Fees</u>	81,000	81,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 178,408	\$ 178,408	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,075	21,375	13
14	Buildings, at Historical Cost	374,625	278,503	14
15	Leasehold Improvements, at Historical Cost	25,554	48,696	15
16	Equipment, at Historical Cost	110,035	110,036	16
17	Accumulated Depreciation (book methods)	(167,991)	(157,188)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Non-Care Asset-Ind. Lv. Bldg.</u>		100,861	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 386,298	\$ 402,283	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 564,706	\$ 580,691	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 533,159	\$ 533,159	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,015	18,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,940	8,940	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,400	26,400	32
33	Accrued Interest Payable	3,650	3,650	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	12,577	12,577	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 602,741	\$ 602,741	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	815,004	815,004	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	15,667	15,667	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 830,671	\$ 830,671	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,433,412	\$ 1,433,412	46
47	TOTAL EQUITY(page 18, line 24)	\$ (868,706)	\$ (852,721)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 564,706	\$ 580,691	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (496,410)	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)	\$ (496,411)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(372,295)	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)	\$ (372,295)	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)	\$ (868,706)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Rock Falls Rehabilitation & Health Care Center** # **0047530** Report Period Beginning: **1/1/2010**Ending: **12/31/2010****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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,331,638	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,331,638	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	6,103	14
15	Telephone, Television and Radio	1,650	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,753	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	831	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 831	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	136	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 136	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,340,358	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	490,585	31
32	Health Care	607,223	32
33	General Administration	461,984	33
B. Capital Expense			
34	Ownership	113,608	34
C. Ancillary Expense			
35	Special Cost Centers	8,045	35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,712,653	40
41	Income before Income Taxes (line 30 minus line 40)**	(372,295)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (372,295)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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 **Rock Falls Rehabilitation & Health Care Center**

0047530

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 57,260	\$ 27.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,925	2,965	87,769	29.60	3
4	Licensed Practical Nurses	5,639	6,018	118,187	19.64	4
5	CNAs & Orderlies	22,873	23,640	217,834	9.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	2,055	19,211	9.35	9
10	Activity Assistants					10
11	Social Service Workers	1,586	1,618	21,646	13.38	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,199	13.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,335	10,727	88,167	8.22	15
16	Dishwashers					16
17	Maintenance Workers	2,977	2,977	39,935	13.41	17
18	Housekeepers	8,392	8,793	77,909	8.86	18
19	Laundry	3,253	3,193	26,426	8.28	19
20	Administrator	2,080	2,080	66,950	32.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,890	2,054	27,974	13.62	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: Care Plan Coord.	1,860	1,860	38,878	20.90	32
33	Other(specify) <u>Transportation</u>	149	149	1,493	10.02	33
34	TOTAL (lines 1 - 33)	70,026	72,289	\$ 917,838 *	\$ 12.70	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	12,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,552	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,752		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	38	\$ 1,133	10(3)	50
51	Licensed Practical Nurses	147	4,956	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	185	\$ 6,089		53

Rock Falls Rehabilitation & Health Care Center

Period Beginning 1/1/2010
Period End 12/31/2010

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				#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation				#DIV/0!
Marketing				#DIV/0!
TOTAL				

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carolyn McBride	Administrator	0	\$ 66,950	Workers' Compensation Insurance	\$ 19,979	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	16,939	Advertising: Employee Recruitment		
				FICA Taxes	63,621	Health Care Worker Background Check		
				Employee Health Insurance	141,288	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	47	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	778	
				Employee Relations	1,064	Miscellaneous Dues & Subscriptions	351	
				Employee Retirement	371	IHCA Dues	1,100	
				Life Insurance	640	Home Office Allocation	922	
				Home Office Allocation	1,590			
						Less: Public Relations Expense	(351)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,950	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 245,492		\$ 5,260		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 140,000				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Home Office Allocation	15
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 140,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 15	
C. Professional Services								
Vendor/Payee	Type		Amount					
E-Health Data Solutions	Computer Services		\$ 2,700					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,700					

* Attach copy of IMRF notifications

**See instructions.

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,700

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	2
Healthcare Resources International	Legal	25
Ginoli & Company	Accountants	794
Bank of America	Accountants	79
Miscellaneous Vendors	Computer Services	10
VisionShare	Computer Services	108
Advanced Answers on Demand	Computer Services	680
Access 2 Go	Computer Services	111
Kemper Technology	Computer Services	94
MediFax	Computer Services	39
LogmeIn	Computer Services	28
Simple LTC	Computer Services	434
Optimizer Systems	Other Professional I	16
Clifton Gunderson	Other Professional I	49
Total (agree to Schedule V, line 19, column 8)		<u>5,169</u>

Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			<u><u>-</u></u>

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530Report Period Beginning: 1/1/2010Ending: 12/31/2010**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. 1,100 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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,763 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,208
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? N/A 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. \$ 6,103
- (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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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 cost have been offset on P5A.