FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049866

Facility Name: Rock Island Nursing & Rehab Center

Address: 2545 24th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 788-0458 **Fax #** (309) 788-5234

HFS ID Number:

Date of Initial License for Current Owners: 03/06/1997

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,605	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	177	TOTALS	177	64,605	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,288		3,987	5,275	8
9	SNF/PED					9
10	ICF	39,011	1,479		40,490	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,299	1,479	3,987	45,765	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.84%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 03/06/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 177 and days of care provided 3,297

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,451	48,113	35,084	291,648		291,648	(15,439)	276,209			1
2	Food Purchase		233,018		233,018	(16,148)	216,870	(75)	216,795			2
3	Housekeeping	173,834	75,271		249,105		249,105	(2,498)	246,607			3
4	Laundry	77,014	17,053	10,740	104,807		104,807	(359)	104,448			4
5	Heat and Other Utilities			157,054	157,054		157,054	(17,935)	139,119			5
6	Maintenance	57,264	49,739	126,692	233,695		233,695	11,349	245,044			6
7	Other (specify):*							1,475	1,475			7
8	**TOTAL General Services**	516,563	423,194	329,570	1,269,327	(16,148)	1,253,179	(23,482)	1,229,697			8
	B. Health Care and Programs											
9	Medical Director			21,400	21,400		21,400		21,400			9
10	Nursing and Medical Records	1,937,049	287,102	46,924	2,271,075		2,271,075	(34,889)	2,236,186			10
10a	Therapy	97,934		37,042	134,976		134,976	(12,957)	122,019			10a
11	Activities	95,397	12,012		107,409		107,409		107,409			11
12	Social Services	134,146		4,678	138,824		138,824		138,824			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,442	3,442			15
16	**TOTAL Health Care and Programs**	2,264,526	299,114	110,044	2,673,684		2,673,684	(44,404)	2,629,280			16
	C. General Administration											
17	Administrative	72,063		87,096	159,159		159,159	(13,713)	145,446			17
18	Directors Fees											18
19	Professional Services			197,345	197,345	(6,176)	191,169	(124,170)	66,999			19
20	Dues, Fees, Subscriptions & Promotions			51,503	51,503		51,503	(31,277)	20,226			20
21	Clerical & General Office Expenses	113,414	36,694	141,875	291,983		291,983	277	292,260			21
22	Employee Benefits & Payroll Taxes			368,462	368,462	16,148	384,610		384,610			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,038	4,038		4,038	681	4,719			24
25	Other Admin. Staff Transportation			8,329	8,329		8,329	5,576	13,905			25
26	Insurance-Prop.Liab.Malpractice			112,180	112,180		112,180	1,012	113,192			26
27	Other (specify):*							28,757	28,757			27
28	**TOTAL General Administration**	185,477	36,694	970,828	1,192,999	9,972	1,202,971	(132,857)	1,070,114			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,966,566	759,002	1,410,442	5,136,010	(6,176)	5,129,834	(200,743)	4,929,091			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Island Nursing & Rehab Center #0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			111,416	111,416		111,416	165,303	276,719			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,350	76,350		76,350	94,818	171,168			32
33	Real Estate Taxes					6,176	6,176	51,278	57,454			33
34	Rent-Facility & Grounds			549,000	549,000		549,000	(267,610)	281,390			34
35	Rent-Equipment & Vehicles			6,004	6,004		6,004	6,424	12,428			35
36	Other (specify):*							7,617	7,617			36
37	**TOTAL Ownership**			742,770	742,770	6,176	748,946	57,830	806,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	104,204	174,024	250,420	528,648		528,648	(809)	527,839			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,908	96,908		96,908		96,908			42
43	Other (specify):*			333	333		333	(333)				43
44	**TOTAL Special Cost Centers**	104,204	174,024	347,661	625,889		625,889	(1,142)	624,747			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,070,770	933,026	2,500,873	6,504,669		6,504,669	(144,055)	6,360,614			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,638)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	156,391	30		9
10	Interest and Other Investment Income	(123)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	02		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	(6,500)	20		18
19	Entertainment				19
20	Contributions	(2,611)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,003)	21		24
25	Fund Raising, Advertising and Promotional	(16,541)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(750)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(70,368)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,218)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,837)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (123,837)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (144,055)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (5,646)	21	1
2	COPE Dues	(5,786)	20	2
3	Non-allowable Legal	(6,675)	19	3
4	Capitalized R&M	(13,485)	06	4
5	Marketing Expense	(333)	43	5
6	Prior Period Medical Expenses	(1,654)	10	6
7				7
8	Building Company:			8
9	Amortization	(5,143)	36	9
10	Fees	(3,279)	21	10
11	Professional Fees	(28,215)	19	11
12	Replacement Tax	(152)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(70,368)		49

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Rock Island Nursing & Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(14,060)	(1,379)							(15,439)	1
2	Food Purchase	(75)											(75)	2
3	Housekeeping					(2,498)							(2,498)	3
4	Laundry					(359)							(359)	4
5	Heat and Other Utilities	(19,638)			1,703								(17,935)	5
6	Maintenance	(13,485)	34,337	(10,060)	557								11,349	6
7	Other (specify):*			676	799								1,475	7
8	**TOTAL General Services**	(33,198)	34,337	(9,384)	(11,001)	(4,236)							(23,482)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,654)		(27,697)	5,222	(10,760)							(34,889)	10
10a	Therapy				(12,957)								(12,957)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,646	1,796								3,442	15
16	**TOTAL Health Care and Programs**	(1,654)		(26,051)	(5,939)	(10,760)							(44,404)	16
	C. General Administration													
17	Administrative			(58,794)	45,081								(13,713)	17
18	Directors Fees													18
19	Professional Services	(34,890)	28,215	(128,021)	10,526								(124,170)	19
20	Fees, Subscriptions & Promotions	(31,438)		161									(31,277)	20
21	Clerical & General Office Expenses	(69,830)	3,431	66,626	50								277	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			681									681	24
25	Other Admin. Staff Transportation			5,576									5,576	25
26	Insurance-Prop.Liab.Malpractice			927	85								1,012	26
27	Other (specify):*			18,841	9,916								28,757	27
28	**TOTAL General Administration**	(136,158)	31,646	(94,003)	65,658								(132,857)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(171,010)	65,983	(129,438)	48,718	(14,996)							(200,743)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Island Nursing & Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	156,391	2,803		6,109								165,303	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(123)	113,745	(23,894)	5,090								94,818	32
33	Real Estate Taxes		48,575		2,703								51,278	33
34	Rent-Facility & Grounds		(267,610)										(267,610)	34
35	Rent-Equipment & Vehicles			6,424									6,424	35
36	Other (specify):*	(5,143)	12,760										7,617	36
37	**TOTAL Ownership**	151,125	(89,727)	(17,470)	13,902								57,830	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(809)							(809)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(333)											(333)	43
44	**TOTAL Special Cost Centers**	(333)				(809)							(1,142)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,218)	(23,744)	(146,908)	62,620	(15,805)							(144,055)	45

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
See Attached		See Attached		See Attached		
				Rock Island Real Estate LLC		Building Company

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 549,000	Rock Island Real Estate, LLC	100.00%	$	$ (549,000)	1
2	V	32	Interest Income	2,484	Rock Island Real Estate, LLC	100.00%		(2,484)	2
3	V	36	Amortization		Rock Island Real Estate, LLC	100.00%	5,143	5,143	3
4	V	30	Depreciation		Rock Island Real Estate, LLC	100.00%	2,803	2,803	4
5	V	21	Fees		Rock Island Real Estate, LLC	100.00%	3,279	3,279	5
6	V	36	Insurance		Rock Island Real Estate, LLC	100.00%	7,617	7,617	6
7	V	32	Interest Expense		Rock Island Real Estate, LLC	100.00%	116,229	116,229	7
8	V	19	Professional Fees		Rock Island Real Estate, LLC	100.00%	28,215	28,215	8
9	V	33	Real Estate Taxes		Rock Island Real Estate, LLC	100.00%	48,575	48,575	9
10	V	34	Rent - Base		Rock Island Real Estate, LLC	100.00%	204,366	204,366	10
11	V	34	Rent - Escrow		Rock Island Real Estate, LLC	100.00%	77,024	77,024	11
12	V	06	Repairs		Rock Island Real Estate, LLC	100.00%	34,337	34,337	12
13	V	21	Replacement Tax		Rock Island Real Estate, LLC	100.00%	152	152	13
14	Total			$ 551,484			$ 527,740	$ * (23,744)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 19,116	S.I.R. MANAGEMENT, INC.	100.00%	$ 9,056	$ (10,060)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	676	676	16
17	V	10	NURSING	38,232	S.I.R. MANAGEMENT, INC.	100.00%	10,535	(27,697)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,646	1,646	18
19	V	19	PROFESSIONAL FEES	129,444	S.I.R. MANAGEMENT, INC.	100.00%	1,423	(128,021)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	161	161	20
21	V	21	CLERICAL & GENERAL	38,232	S.I.R. MANAGEMENT, INC.	100.00%	40,031	1,799	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	681	681	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,576	5,576	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	927	927	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,611	5,611	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(23,894)	(23,894)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,424	6,424	27
28	V								28
29	V	17	ADMINISTRATIVE	77,532	S.I.R. MANAGEMENT, INC.	100.00%	18,738	(58,794)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	709		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	64,827	64,827	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,230	13,230	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 302,556			$ 156,357	$ * (146,908)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 19,116	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,056	$ (14,060)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	799	799	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,222	5,222	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	822	822	18
19	V	17	ADMIN./LEGAL SALARIES	9,564	S.I.R. MANAGEMENT, INC.	100.00%	54,645	45,081	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,486	10,486	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	9,916	9,916	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	19,116	S.I.R. MANAGEMENT, INC.	100.00%	6,159	(12,957)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	974	974	25
26	V								26
27	V	6	MAINTENANCE SALARIES		S.I.R. MANAGEMENT, INC.	100.00%			27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,703	1,703	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	557	557	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	40	40	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	50	50	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	85	85	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,109	6,109	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,090	5,090	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,703	2,703	37
38	V								38
39	Total			$ 47,796			$ 110,416	$ * 62,620	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 20,688	Xcel Supply, LLC	100.00%	$ 19,309	$ (1,379)	15
16	V	3	Housekeeping	37,485	Xcel Supply, LLC	100.00%	34,987	(2,498)	16
17	V	4	Laundry	5,390	Xcel Supply, LLC	100.00%	5,031	(359)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	161,457	Xcel Supply, LLC	100.00%	150,697	(10,760)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	12,144	Xcel Supply, LLC	100.00%	11,335	(809)	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			$ 237,164			$ 221,359	$ * (15,805)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 120,809	$ 120,809	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	120,809	CCS Employee Benefits Group	100.00%		(120,809)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$ 120,809			$ 120,809	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Giannini	Relative	Administrative	0.00%	See Attached	1.99	4.98%	Alloc. Salary	$ 9,487	17-7	1
2	Bryan Barrish	Relative	Administrative	0.00%	See Attached	2.28	5.07%	Alloc. Salary	11,376	17-7	2
3	Kristen Barrish	Relative	Clerical	0.00%	See Attached	0.97	5.71%	Alloc. Salary	2,114	21-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.84	5.68%	Alloc. Salary	6,062	17-7	4
5	Ninita Guzman	Relative	Dietary	0.00%	See Attached	2.84	5.68%	Alloc. Salary	5,056	1-7	5
6	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	1.59	2.65%	Alloc. Salary	5,547	17-7	6
7	Fay Chin	Shareholder	Nursing	1.13%	See Attached	2.28	5.70%	Alloc. Salary	5,222	10-7	7
8	Andrew Chin	Relative	Clerical	0.00%	See Attached	2.28	5.70%	Alloc. Salary	3,800	21-7	8
9	Patricia McDiarmid	Shareholder	Administrative	1.13%	See Attached	2.84	5.68%	Alloc. Salary	7,150	17-7	9
10	Ronald Nunziato	Shareholder	Administrative	1.13%	See Attached	2.28	5.70%	Alloc. Salary	8,988	17-7	10
11	Jeff Oravec	Shareholder	Administrative	1.13%	See Attached	2.28	5.70%	Alloc. Salary	7,362	17-7	11
12	see second page 7 for the detail of the additional owner and related compensation								23,156		12
13								TOTAL	$ 95,320		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 Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	804,585	12	$ 159,205	$ 76,299	45,765	$ 9,056	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		45,765	676	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	45,765	10,535	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		45,765	1,646	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	45,765	1,423	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		45,765	161	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	45,765	40,031	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		45,765	681	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		45,765	5,576	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		45,765	927	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		45,765	5,611	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		45,765	(23,894)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		45,765	6,424	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	45,765	18,738	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		45,765	709	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	45,765	64,827	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		45,765	13,230	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,748,883	$ 2,300,573		$ 156,357	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	804,585	12	$ 88,890	$ 88,890	45,765	$ 5,056	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		45,765	799	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	45,765	5,222	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		45,765	822	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	45,765	54,645	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		45,765	10,486	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		45,765	9,916	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	19,116	6,159	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	273,888	12	13,949		19,116	974	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018			13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079				14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		733	1,703	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		733	557	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		733	40	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		733	50	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		733	85	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		733	6,109	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		733	5,090	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		733	2,703	23
24										24
25	TOTALS					$ 2,238,902	$ 1,499,668		$ 110,416	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 19,309	1
2	3	Housekeeping	Direct Allocation						34,987	2
3	4	Laundry	Direct Allocation						5,031	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						150,697	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation							10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						11,335	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	TOTALS					$	$		$ 221,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 120,809	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 120,809	25

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Centrue Bank		X	Mortgage Payable			$	$ 4,566,823			$ 116,229	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				470,000			76,350	6
7	Shareholder Loan		X					900,000				7
8	See Supplemental Schedule										5,090	8
9	TOTAL Facility Related						$	$ 5,936,823			$ 197,669	9
	B. Non-Facility Related*											
10	Interest Incomes		X								(123)	10
11	Interest Income - SIR Mgmt	X									(23,894)	11
12	Interest Income - Bldg Co.		X								(2,484)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (26,501)	14
15	TOTALS (line 9+line14)						$	$ 5,936,823			$ 171,168	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 7,617 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from SIR Mgmt	X					$	$			$ 5,090	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5,090	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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.	$	163,404	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.)	$	106,107	2
3. Under or (over) accrual (line 2 minus line 1).	$	(57,297)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	108,575	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.**	$	6,176	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	57,454	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	131,112	8
2006	136,536	9
2007	123,279	10
2008	124,475	11
2009	103,404	12

Real Estate Tax = $103,404 x 1.05 = $108,575
Allocation to SIR Management = $2,703
Beginning Accrual adjusted by $163,404, no accrual in prior year

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 Island Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-341-78-00	Long Term Care Property	$ 101,952.12	$ 101,952.12
2.	10-341-79-00	Long Term Care Property	$ 1,452.12	$ 1,452.12
3.	See Attached	See Attached	$ 80,891.59	$ 3,605.57
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 184,295.83	$ 107,009.81

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? X YES _____ NO

If YES, attach an explanation & 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Island Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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.

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,494 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 + Basement

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	224,770	1997	$ 420,000	1
2					2
3	TOTALS	224,770		$ 420,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	396	396	3,195	9
10	Various			2003	5,954		20	216	216	1,533	10
11	Various			2004	9,240		20	336	336	2,198	11
12	Various			2005	48,760		20	2,139	2,139	11,677	12
13	Various			2006	39,068		20	1,421	1,421	6,780	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
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30											30
31											31
32											32
33											33
34											34
35											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 Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)		3,667,118	2,803		97,766	94,963	1,259,831	67
68	Related Party Allocations (Pages 12H & 12I)		85,207	2,803		3,760	957	33,732	68
69	Financial Statement Depreciation			111,416			(111,416)		69
70	TOTAL (lines 4 thru 69)		$ 3,866,234	$ 117,022		$ 106,034	$ (10,988)	$ 1,318,946	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,866,234	$ 117,022		$ 106,034	$ (10,988)	$ 1,318,946	1
2	Water Heater	2008	6,570		20	1,314	1,314	3,833	2
3	Nurse Station	2008	19,200		20	1,920	1,920	4,640	3
4	Floor Work	2008	75,693		20	7,569	7,569	18,292	4
5	Ceiling Tile	2008	35,437		20	3,544	3,544	9,745	5
6	Draperies	2008	42,557		20	8,511	8,511	19,860	6
7	Painting	2008	226,884		20	22,688	22,688	52,940	7
8	Doors	2008	3,291		20	329	329	686	8
9	Compressor	2008	5,717		20	1,143	1,143	2,763	9
10	Handrails	2008	156,327		20	15,633	15,633	35,174	10
11	A/C Units	2008	4,386		20	219	219	548	11
12	Heat / Cool Units	2008	2,632		20	132	132	307	12
13	Flooring	2008	57,770		20	5,777	5,777	12,035	13
14	Signage	2009	3,992		20	399	399	798	14
15	Bath/Shower Room	2009	4,175		20	209	209	400	15
16	Flooring	2009	20,323		20	1,016	1,016	1,948	16
17	Beauty Shop- Flooring, Wood Blinds, Furnishings	2009	11,709		20	1,171	1,171	2,244	17
18	Beauty Shop/Office- Construction, Wall Work, Paint	2009	12,195		20	610	610	1,169	18
19	Firestopping	2009	28,918		20	1,446	1,446	2,651	19
20	Flooring	2009	3,205		20	160	160	294	20
21	Baseboard	2009	8,633		20	432	432	755	21
22	Generator	2009	64,744		20	3,237	3,237	5,395	22
23	Exterior Sign	2009	10,344		20	517	517	862	23
24	Generator Panel	2009	4,320		20	216	216	360	24
25	Emergency Panel	2009	7,465		20	373	373	591	25
26	Wiring Recepticles	2009	5,654		20	283	283	448	26
27	Light Fixtures	2009	2,914		20	291	291	413	27
28	Elevator	2009	15,382		20	769	769	1,025	28
29	Elevator	2009	15,382		20	769	769	1,025	29
30	Doors	2009	3,108		20	311	311	414	30
31	Doors & Hardware	2009	8,587		20	859	859	1,145	31
32	Closet Doors	2009	7,225		20	723	723	963	32
33	Doors	2009	3,186		20	319	319	398	33
34	TOTAL (lines 1 thru 33)		$ 4,744,159	$ 117,022		$ 188,923	$ 71,901	$ 1,503,068	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,744,159	$ 117,022		$ 188,923	$ 71,901	$ 1,503,068	1
2	Doors	2009	2,630		20	263	263	329	2
3	Chiller Unit	2009	5,092		20	255	255	382	3
4	Compressor	2009	5,032		20	252	252	356	4
5	Lighting	2009	4,915		20	246	246	328	5
6	Lighting	2009	6,395		20	320	320	400	6
7	Wiring In Elevator	2009	3,474		20	174	174	203	7
8	Asphalt-Parking Lot	2009	5,475		20	274	274	297	8
9	Rofftop Motors	2009	3,995		20	200	200	216	9
10	Electric Work	2009	2,501		20	250	250	271	10
11	Added 3 Voice And Data Runs	2009	2,649		20	132	132	143	11
12	Receptacles	2010	8,185		20	136	136	136	12
13	Chiller Conduit	2010	5,557		20	278	278	278	13
14	12 Volt Circuit	2010	3,738		20	187	187	187	14
15	Door Alarm Repair	2010	4,190		20	210	210	210	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,807,987	$ 117,022		$ 192,098	$ 75,076	$ 1,506,804	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,807,987	$ 117,022		$ 192,098	$ 75,076	$ 1,506,804	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,807,987	$ 117,022		$ 192,098	$ 75,076	$ 1,506,804	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,807,987	$ 117,022		$ 192,098	$ 75,076	$ 1,506,804	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,807,987	$ 117,022		$ 192,098	$ 75,076	$ 1,506,804	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1975	3,579,244	2,803	39	92,208	89,405	1,225,641	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring, Wallcovering, Window Treatment, Doors	1997	50,964		20	3,310	3,310	29,607	9
10	Windows	1998	2,278		20	114	114	949	10
11	Walk-In Freezer Compressor	2000	2,097		20	105	105	943	11
12	Electrical Work	2001	1,854		20	93	93	755	12
13									13
14	Electrical Work - Resident Rooms	2010	7,985		20	399	399	399	14
15	Wall Removal - 4th Floor Dining	2010	8,100		20	405	405	405	15
16	Outdoor Fence	2010	6,570		20	329	329	329	16
17	Kitchen Lighting	2010	8,026		10	803	803	803	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 3,667,118	$ 2,803		$ 97,766	$ 94,963	$ 1,259,831	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from SIR Properties - SIR Management	1993	25,763	818	35	736	(82)	12,881	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management	1993	6,532	182	20	324	142	5,829	9
10	Allocated from SIR Management	1994	20		10			20	10
11	Allocated from SIR Management	1995	149		20	7	7	115	11
12	Allocated from SIR Management	1997	10,037	225	20	502	277	6,930	12
13	Allocated from SIR Management	1999	789		20	39	39	444	13
14	Allocated from SIR Management	1999			20				14
15	Allocated from SIR Management	2000	932		20	47	47	491	15
16	Allocated from SIR Management	2007	2,994	320	20	150	(170)	478	16
17	Allocated from SIR Management	2008	8,250	825	20	520	(305)	1,479	17
18	Allocated from SIR Management	2009	20,501	187	20	1,025	838	1,276	18
19									19
20	Allocated from SIR Properties - SIR Management	2010	1,555		20	26	26	26	20
21	Allocated from SIR Properties - SIR Management	2009	1,547	189	20	77	(112)	139	21
22	Allocated from SIR Properties - SIR Management	2007	451	49	20	23	(26)	90	22
23	Allocated from SIR Properties - SIR Management	2002	102		20	5	5	44	23
24	Allocated from SIR Properties - SIR Management	1999	3,265		20	163	163	1,877	24
25	Allocated from SIR Properties - SIR Management	1998	1,560		20	78	78	975	25
26	Allocated from SIR Properties - SIR Management	1997	97		20	5	5	70	26
27	Allocated from SIR Properties - SIR Management	1994	245	6	20	12	6	202	27
28	Allocated from SIR Properties - SIR Management	1993	418	2	20	21	19	366	28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 85,207	$ 2,803		$ 3,760	$ 957	$ 33,732	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 608,501	$ 3,099	$ 81,465	$ 78,366	10	$ 390,630	71
72	Current Year Purchases	31,185	93	2,996	2,903	10	2,996	72
73	Fully Depreciated Assets	22,345		45	45	10	22,345	73
74								74
75	TOTALS	$ 662,031	$ 3,192	$ 84,507	$ 81,315		$ 415,971	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	Facility	Allocated from SIR Mgmt	1988	$ 1,508	$ 113	$ 113	$	5	$ 113	76
77										77
78										78
79										79
80	TOTALS			$ 1,508	$ 113	$ 113	$		$ 113	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)	$ 5,891,526	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,327	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,718	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 156,391	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,922,888	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					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 Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:		177		$ 281,390			3
4	Additions							4
5								5
6								6
7	TOTAL		177		$ 281,390 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental 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	$

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: $ 12,428 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 109,742	$		$ 109,742	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,976			27,976	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			112,702			112,702	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				81,469		81,469	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			104,204			92,555		196,759	13
14	TOTAL			$ 104,204		$ 250,420	$ 174,024		$ 528,648	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 9,801	$ 25,452	1
2	Cash-Patient Deposits	37,265	37,265	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,188,795	1,188,795	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,696	52,883	6
7	Other Prepaid Expenses	13,448	13,448	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		275,713	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,279,005	$ 1,593,556	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	726,555	856,684	15
16	Equipment, at Historical Cost	444,606	478,688	16
17	Accumulated Depreciation (book methods)	(230,603)	5,176,150	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(16,667)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	19,426	19,426	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 959,984	$ 6,540,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,238,989	$ 8,133,556	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,594	$ 218,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,962	37,962	28
29	Short-Term Notes Payable	1,370,000	1,370,000	29
30	Accrued Salaries Payable	188,758	188,758	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,055	22,055	31
32	Accrued Real Estate Taxes(Sch.IX-B)		108,575	32
33	Accrued Interest Payable		11,010	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,837,369	$ 1,956,954	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,566,823	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,566,823	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,837,369	$ 6,523,777	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 401,620	$ 1,609,779	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,238,989	$ 8,133,556	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 173,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 173,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	122,359	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) **Contributed Capital**	106,203	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 228,562	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)**	$ 401,620	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,207,976	1
2	Discounts and Allowances for all Levels	(557,653)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,650,323	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	687,510	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 687,510	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	119,284	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,023	19
20	Radiology and X-Ray	1,915	20
21	Other Medical Services	150,850	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 289,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	123	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 123	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,627,028	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,269,327	31
32	Health Care	2,673,684	32
33	General Administration	1,192,999	33
	B. Capital Expense		
34	Ownership	742,770	34
	C. Ancillary Expense		
35	Special Cost Centers	528,981	35
36	Provider Participation Fee	96,908	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,504,669	40
41	**Income before Income Taxes (line 30 minus line 40)****	122,359	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 122,359	43

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

****** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,222	$ 66,695	$ 30.02	1
2	Assistant Director of Nursing	2,029	2,166	52,187	24.09	2
3	Registered Nurses	5,535	5,878	132,318	22.51	3
4	Licensed Practical Nurses	35,620	37,764	711,468	18.84	4
5	CNAs & Orderlies	74,466	74,512	782,334	10.50	5
6	CNA Trainees					6
7	Licensed Therapist	4,203	4,219	104,204	24.70	7
8	Rehab/Therapy Aides	7,306	7,846	97,934	12.48	8
9	Activity Director	1,997	2,086	30,982	14.85	9
10	Activity Assistants	5,923	6,334	64,415	10.17	10
11	Social Service Workers	9,736	10,492	134,146	12.79	11
12	Dietician					12
13	Food Service Supervisor	2,099	2,327	43,604	18.74	13
14	Head Cook	8,852	9,561	92,044	9.63	14
15	Cook Helpers/Assistants	8,773	8,857	72,803	8.22	15
16	Dishwashers					16
17	Maintenance Workers	4,143	4,375	57,264	13.09	17
18	Housekeepers	18,053	19,180	173,834	9.06	18
19	Laundry	8,193	8,677	77,014	8.88	19
20	Administrator	2,013	2,086	72,063	34.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,173	8,522	113,414	13.31	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	5,976	6,425	107,697	16.76	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,439	6,827	84,350	12.36	33
34	TOTAL (lines 1 - 33)	221,566	230,356	$ 3,070,770 *	$ 13.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,968	01-03	35
36	Medical Director	Monthly	21,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	38,232	10-03	38
39	Pharmacist Consultant	Monthly	8,692	10-03	39
40	Physical Therapy Consultant	133	7,946	10a-03	40
41	Occupational Therapy Consultant	145	8,679	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	1,301	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	87	4,678	12-03	45
46	Other(specify)				46
47	Specialized Services	Monthly	19,116	10a-03	47
48	Director of Food Service	Monthly	19,116	01-03	48
49	TOTAL (lines 35 - 48)	386	$ 145,128		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn May	Administrator	0.00%	$ 72,063
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,063

B. Administrative - Other

Description	Amount
SIR Management - Director of Administrative Services	$ 38,232
SIR Management - Ancillary Administrative Charges	39,300
SIR Management - Owners Council Dues	9,564
TOTAL (agree to Schedule V, line 17, col. 3)	$ 87,096
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir of Regulatory Services	$ 19,116
SIR Management	Bookkeeping Fees	74,328
SIR Management	Accounting Fees	36,000
Frost, Ruttenberg, & Rothblatt	Accounting Fees	19,435
Personnel Planners	Unemployment Tax Consult.	3,212
American Data	Data Processing	4,624
Pinnacle	Customer Satisfaction	2,433
E-Health Data Solutions	Data Processing	3,600
Honkamp Krueger	Tax Credit Report	5,385
MDI Achieve	Computer Services	3,569
See Attached	Legal	25,213
See Supplemetal Schedule		430
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 197,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,747
Unemployment Compensation Insurance	26,568
FICA Taxes	230,537
Employee Health Insurance	68,114
Employee Meals	16,148
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,749
Reversal of Prior Vacation Pay Accrual	(42,253)
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,610

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 994
Advertising: Employee Recruitment	6,666
Health Care Worker Background Check	
(Indicate # of checks performed 140)	3,470
Patient Background Checks	
Dues & Subscriptions	8,685
Licenses & Permits	250
Advertising & Promotion	16,541
Allocated from SIR Management	161
Less: Public Relations Expense	( )
Non-allowable advertising	(16,541)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,226

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,038
Allocated from SIR Management	681
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,719

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $13,721**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,060** 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? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
River Park Healthcare Center #0042549

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,908**
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. $ **16,148** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% in 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.