FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0050617

Facility Name: Rochelle Gardens Care Center

Address: 1021 Caron Road (Number) Rochelle (City) 61068 (Zip Code)

County: Ogle

Telephone Number: (815) 562-4047 **Fax #** (815) 562-6689

HFS ID Number:

Date of Initial License for Current Owners: 10/31/2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 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) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	13,711	2,990		16,701	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,711	2,990		16,701	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.83%

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 [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	106,616	10,661		117,277		117,277	3,369	120,646			1
2	Food Purchase		100,470		100,470		100,470	(1,274)	99,196			2
3	Housekeeping	66,553	13,283		79,836		79,836	22	79,858			3
4	Laundry	35,735	6,394		42,129		42,129		42,129			4
5	Heat and Other Utilities			61,556	61,556		61,556	220	61,776			5
6	Maintenance	31,187	6,388	16,236	53,811		53,811	1,374	55,185			6
7	Other (specify):* Home Off. Ben. All.							768	768			7
8	**TOTAL General Services**	240,091	137,196	77,792	455,079		455,079	4,479	459,558			8
	B. Health Care and Programs											
9	Medical Director			16,125	16,125		16,125		16,125			9
10	Nursing and Medical Records	737,702	50,457	14,528	802,687		802,687	34	802,721			10
10a	Therapy											10a
11	Activities	25,935	1,301	110	27,346		27,346	(594)	26,752			11
12	Social Services	34,378	37		34,415		34,415		34,415			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	798,015	51,795	30,763	880,573		880,573	(560)	880,013			16
	C. General Administration											
17	Administrative			151,000	151,000		151,000	(85,778)	65,222			17
18	Directors Fees											18
19	Professional Services			5,634	5,634		5,634	4,684	10,318			19
20	Dues, Fees, Subscriptions & Promotions			3,685	3,685		3,685	271	3,956			20
21	Clerical & General Office Expenses	35,263	2,059	7,649	44,971		44,971	31,442	76,413			21
22	Employee Benefits & Payroll Taxes			188,471	188,471		188,471		188,471			22
23	Inservice Training & Education							112	112			23
24	Travel and Seminar							33	33			24
25	Other Admin. Staff Transportation			5,669	5,669		5,669	3,112	8,781			25
26	Insurance-Prop.Liab.Malpractice			31,761	31,761		31,761	781	32,542			26
27	Other (specify):* Home Off. Ben. All.							12,766	12,766			27
28	**TOTAL General Administration**	35,263	2,059	393,869	431,191		431,191	(32,577)	398,614			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,073,369	191,050	502,424	1,766,843		1,766,843	(28,658)	1,738,185			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rochelle Gardens Care Center #0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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			107,542	107,542		107,542	(17,052)	90,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,237	7,237		7,237	21,840	29,077			32
33	Real Estate Taxes			8,342	8,342		8,342	278	8,620			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,072	10,072		10,072	492	10,564			35
36	Other (specify):*											36
37	**TOTAL Ownership**			133,193	133,193		133,193	5,558	138,751			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):* Non-allowable Costs		15	10,509	10,524		10,524	(10,524)				43
44	**TOTAL Special Cost Centers**		15	51,024	51,039		51,039	(10,524)	40,515			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,073,369	191,065	686,641	1,951,075		1,951,075	(33,624)	1,917,451			45

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	(1,290)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,399)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,565)	30		9
10	Interest and Other Investment Income	(1,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(83)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,378)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,845)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(426)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,403)		$	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)	1,779	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,779		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,624)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Rochelle Gardens Care Center

ID# 0050617

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	$ (13)	21	1
2	Offset Transportation Revenue	(594)	11	2
3	Resident Flowers	(7)	43	3
4	Special Events	188	43	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
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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**	(426)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	0	3,369	0	0	0	0	0	0	0	0	0	3,369	1
2	Food Purchase	(1,290)	16	0	0	0	0	0	0	0	0	0	(1,274)	2
3	Housekeeping	0	22	0	0	0	0	0	0	0	0	0	22	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	220	0	0	0	0	0	0	0	0	0	220	5
6	Maintenance	0	1,374	0	0	0	0	0	0	0	0	0	1,374	6
7	Other (specify):*	0	768	0	0	0	0	0	0	0	0	0	768	7
8	**TOTAL General Services**	(1,290)	5,769	0	0	0	0	0	0	0	0	0	4,479	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	34	0	0	0	0	0	0	0	0	0	34	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(594)	0	0	0	0	0	0	0	0	0	0	(594)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(594)	34	0	0	0	0	0	0	0	0	0	(560)	16
	C. General Administration													
17	Administrative	0	(85,778)	0	0	0	0	0	0	0	0	0	(85,778)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,855	0	829	0	0	0	0	0	0	0	4,684	19
20	Fees, Subscriptions & Promotions	0	0	271	0	0	0	0	0	0	0	0	271	20
21	Clerical & General Office Expenses	(13)	0	31,409	46	0	0	0	0	0	0	0	31,442	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	112	0	0	0	0	0	0	0	0	112	23
24	Travel and Seminar	0	0	33	0	0	0	0	0	0	0	0	33	24
25	Other Admin. Staff Transportation	0	0	2,886	226	0	0	0	0	0	0	0	3,112	25
26	Insurance-Prop.Liab.Malpractice	0	0	781	0	0	0	0	0	0	0	0	781	26
27	Other (specify):*	0	0	12,766	0	0	0	0	0	0	0	0	12,766	27
28	**TOTAL General Administration**	(13)	(81,923)	48,258	1,101	0	0	0	0	0	0	0	(32,577)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,897)	(76,120)	48,258	1,101	0	0	0	0	0	0	0	(28,658)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(21,565)	0	4,513	0	0	0	0	0	0	0	0	(17,052)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,417)	0	5,432	17,825	0	0	0	0	0	0	0	21,840	32
33	Real Estate Taxes	0	0	278	0	0	0	0	0	0	0	0	278	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	492	0	0	0	0	0	0	0	0	492	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,982)	0	10,715	17,825	0	0	0	0	0	0	0	5,558	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,524)	0	0	0	0	0	0	0	0	0	0	(10,524)	43
44	**TOTAL Special Cost Centers**	(10,524)	0	0	0	0	0	0	0	0	0	0	(10,524)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,403)	(76,120)	58,973	18,926	0	0	0	0	0	0	0	(33,624)	45

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,369	$ 3,369	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	16	16	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	220	220	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,374	1,374	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	768	768	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	34	34	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	151,000	Petersen Health Care, Inc.	100.00%	65,222	(85,778)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,855	3,855	12
13	V								13
14	Total			$ 151,000			$ 74,880	$ * (76,120)	14

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 271	$ 271	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,409	31,409	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	112	112	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	33	33	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,886	2,886	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	781	781	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,766	12,766	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,513	4,513	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,432	5,432	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	278	278	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	492	492	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			$			$ 58,973	$ * 58,973	39

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$	Petersen Health Network, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health Network, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health Network, LLC	100.00%	829	829	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		27
28	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	46	46	28
29	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	226	226	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Network, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	17,825	17,825	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total			$			$ 18,926	$ * 18,926	39

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach. MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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											1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,542,131	77	$ 311,109	$ 308,619	16,701	$ 3,369	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	16,701	16	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	16,701	22	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	16,701	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	16,701	220	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	16,701	1,374	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	16,701	768	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	16,701	34	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	16,701	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	16,701	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	16,701	65,222	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	16,701	3,855	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	16,701	271	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	16,701	31,409	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	16,701	112	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	16,701	33	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	16,701	2,886	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	16,701	781	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	16,701	12,766	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	16,701	4,513	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	16,701	5,432	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	16,701	278	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	16,701	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	16,701	492	24
25	TOTALS					$ 11,242,734	$ 7,781,943		$ 133,853	25

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	209,680	12	$	$	16,701	$	1
2	2	Food	Resident Days	209,680	12			16,701		2
3	3	Housekeeping	Resident Days	209,680	12			16,701		3
4	4	Laundry	Resident Days	209,680	12			16,701		4
5	5	Utilities	Resident Days	209,680	12			16,701		5
6	6	Maintenance	Resident Days	209,680	12			16,701		6
7	7	Mgmt. Allocation of Benefits	Resident Days	209,680	12			16,701		7
8	10	Nursing and Medical Records	Resident Days	209,680	12			16,701		8
9	10A	Therapy	Resident Days	209,680	12			16,701		9
10	15	Mgmt. Allocation of Benefits	Resident Days	209,680	12			16,701		10
11	17	Administrative	Resident Days	209,680	12			16,701		11
12	19	Professional Services	Resident Days	209,680	12	10,410		16,701	829	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	209,680	12			16,701		13
14	21	Clerical and General Office	Resident Days	209,680	12	575		16,701	46	14
15	22	Employee Benefits & Payroll	Resident Days	209,680	12	(1)		16,701		15
16	24	Travel and Seminar	Resident Days	209,680	12			16,701		16
17	25	Other Admin. Staff Transport.	Resident Days	209,680	12	2,833		16,701	226	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	209,680	12			16,701		18
19	27	Mgmt. Allocation of Benefits	Resident Days	209,680	12			16,701		19
20	30	Depreciation	Resident Days	209,680	12			16,701		20
21	32	Interest	Resident Days	209,680	12	223,794		16,701	17,825	21
22	33	Real Estate Taxes	Resident Days	209,680	12			16,701		22
23	34	Rent-Facility and Grounds	Resident Days	209,680	12			16,701		23
24	35	Rent-Equipment & Vehicles	Resident Days	209,680	12			16,701		24
25	TOTALS					$ 237,611	$		$ 18,926	25

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	The Private Bank		X	Mortgage	Varies	11/1/09	100,304	$ 96,755	12/31/14	Varies	$ 7,237	1
2												2
3								Interest Income Offset			(1,417)	3
4								Home Office Allocation-PHC			5,432	4
5								Home Office Allocation-PHN			17,825	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 100,304	$ 96,755			$ 29,077	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 100,304	$ 96,755			$ 29,077	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Rochelle Gardens Care Center **#** 0050617 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 30,960	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.)	2010	$ 23,052	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,908)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,760	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 278 **TOTAL REFUND** $ 7,510 **For** 2009 **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.		$ 8,620	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	34,717	8
2007	35,073	9
2008	52,826	10
2009	30,009	11
2010	23,052	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rochelle Gardens Care Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0050617

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-100-002	Long-Term Care Facility	$ 23,052.34	$ 23,052.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,052.34	$ 23,052.34

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,863 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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	105,000	2006	$ 60,000	1
2					2
3	TOTALS	105,000		$ 60,000	3

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		2006		$ 1,532,000	$	30	$ 51,067	$ 51,067	$ 280,868	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire System			2006	2,215		15	148	148	814	9
10	Exterior Sign			2007	4,130		15	275	275	1,238	10
11	Draperies			2007	2,537		10	254	254	1,143	11
12	Painting of Dining Room, Entry Halls, Office Walls, Ceilings			2007	1,225		15	82	82	369	12
13	Landscaping			2007	518		15	35	35	157	13
14	Painting of Resident Rooms, Bathrooms, Hallways, and Doors			2007	5,700		15	380	380	1,710	14
15	Painting of C-Wing			2007	2,930		15	195	195	878	15
16	Carpet for Resident Rooms			2007	21,701		15	1,447	1,447	6,511	16
17	Installation of Tile in Main Hall			2007	6,876		15	458	458	2,061	17
18	Wallpaper for Central Area of Nursing Home			2007	1,985		15	132	132	595	18
19	Landscaping			2007	3,852		15	257	257	1,156	19
20	Sprinkler Installation			2009	10,994		15	732	732	1,830	20
21	Smoke Detectors Replacement			2010	5,325		10	532	532	798	21
22	Sprinkler System Repair			2010	9,787		10	978	978	1,467	22
23	Generator Repair			2011	3,177		7	227	227	227	23
24											24
25											25
26											26
27											27
28	Land Improvements Booked					35			(35)		28
29	Building Booked					61,280			(61,280)		29
30	Building Improvement Booked					5,093			(5,093)		30
31											31
32	2011-Home Office Allocation-Building Improvements				7,949			191	191		32
33	2011-Home Office Allocation-Land Improvements				742			47	47		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 Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,623,643	$ 66,408		$ 57,437	$ (8,971)	$ 301,822	70

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 285,402	$ 41,134	$ 28,540	$ (12,594)	10 yrs.	$ 154,318	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,513	4,513			74
75	TOTALS	$ 285,402	$ 41,134	$ 33,053	$ (8,081)		$ 154,318	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77		N/A								77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,969,045	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 107,542	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,490	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,052)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 456,140	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 10,564 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Rochelle Gardens Care Center
0050617

Period Beginning	**1/1/2011**
Period End	**12/31/2011**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	6,144
Dishwasher		708
Laundry Equipment		-
Copier		3,220
Home Office Allocation		492
		10,564

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

It is the policy of this facility to only hire certified nurses aides.

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

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.

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 800	$ 800	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	743,350	743,350	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,862	23,862	6
7	Other Prepaid Expenses	5,883	5,883	7
8	Accounts Receivable (owners or related parties)	24,725	24,725	8
9	Other(specify): Due from prior owner	6,292	6,292	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 804,912	$ 804,912	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,518	60,000	13
14	Buildings, at Historical Cost	1,532,000	1,539,949	14
15	Leasehold Improvements, at Historical Cost	79,897	83,694	15
16	Equipment, at Historical Cost	287,939	285,402	16
17	Accumulated Depreciation (book methods)	(543,646)	(456,140)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,416,708	$ 1,512,905	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,221,620	$ 2,317,817	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,554,838	$ 2,554,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,801	60,801	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,924	5,924	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,760	23,760	32
33	Accrued Interest Payable	602	602	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	37,516	37,516	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,683,441	$ 2,683,441	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	96,755	96,755	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 96,755	$ 96,755	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,780,196	$ 2,780,196	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (558,576)	$ (462,379)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,221,620	$ 2,317,817	48

***(See instructions.)**

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (478,128)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (478,128)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(80,448)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (80,448)	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)**	$ (558,576)	24	*

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 1,867,313	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,867,313	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,290	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,290	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,417	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,417	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	594	28
28a	Miscellaneous Revenue	13	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 607	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,870,627	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	455,079	31
32	Health Care	880,573	32
33	General Administration	431,191	33
	B. Capital Expense		
34	Ownership	133,193	34
	C. Ancillary Expense		
35	Special Cost Centers	10,524	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,951,075	40
41	**Income before Income Taxes (line 30 minus line 40)****	(80,448)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (80,448)	43

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

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

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

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 63,200	$ 30.38	1
2	Assistant Director of Nursing	1,427	1,427	40,654	28.49	2
3	Registered Nurses	5,521	5,536	139,639	25.22	3
4	Licensed Practical Nurses	6,609	6,731	154,667	22.98	4
5	CNAs & Orderlies	27,356	27,524	339,542	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,080	1,080	14,354	13.29	9
10	Activity Assistants	807	807	10,532	13.05	10
11	Social Service Workers	2,187	2,264	34,378	15.18	11
12	Dietician					12
13	Food Service Supervisor	2,255	2,255	26,888	11.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,889	9,037	79,728	8.82	15
16	Dishwashers					16
17	Maintenance Workers	1,655	1,799	31,187	17.34	17
18	Housekeepers	6,925	7,248	66,553	9.18	18
19	Laundry	4,070	4,191	35,735	8.53	19
20	Administrator	2,080	2,241	65,222	29.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,070	2,222	35,263	15.87	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	115	115	1,049	9.12	33
34	TOTAL (lines 1 - 33)	75,126	76,557	$ 1,138,591 *	$ 14.87	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		$		35
36	Medical Director	Monthly	16,125	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,097	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,222		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	62	$ 2,153	L10, C3	50
51	Licensed Practical Nurses	249	9,278	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	311	$ 11,431		53

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Becky Cattani	Administrator	0	$ 6,088
Carol Shepherd	Administrator	0	17,067
Amy Urben	Administrator	0	36,750
David Lenzon	Administrator	0	5,317
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,222

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 151,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 151,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Rochelle Municipal Utilties	Computer Services	$ 240
Comcast Cable	Computer Services	1,098
E-Health Data Solutions	Computer Services	3,485
Sorling, Northrup, Hanna	Legal Services	630
Ogle Co. Recorder of Deeds	Legal Services	41
Honkamp Krueger & Co.	Accounting Fees	140
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,634

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,293
Unemployment Compensation Insurance	31,244
FICA Taxes	80,273
Employee Health Insurance	53,519
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	599
Life Insurance	543
TOTAL (agree to Schedule V, line 22, col.8)	$ 188,471

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	271
Health Care Worker Background Check	
(Indicate # of checks performed 101)	
Patient Background Checks	1,016
Miscellaneous Licenses & Permits	408
Miscellaneous Dues & Subscriptions	0
Home Office Allocation	271
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,956

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	33
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33

**See instructions.

Rochelle Gardens Care Center
0050617
Period Beginning **1/1/2011**
Period End **12/31/2011**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		5,634
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	535
Miscellaneous Vendors	Computer Services	44
Advanced Answers on Demand	Computer Services	2,236
Access 2 Go	Computer Services	220
Kemper Technology	Computer Services	102
MediFax	Computer Services	35
VisionShare/Ability Network	Computer Services	157
Advanced System Design	Computer Services	206
Simple LTC	Computer Services	258
Optimizer Systems	Other Prof Fees	26
Clifton Gunderson	Other Prof Fees	9
Mike Miller	Other Prof Fees	13
OIC Group	Other Prof Fees	3
AllScripts	Other Prof Fees	7
Ginoli & Company	Accountants	829
Total (agree to Schedule V, line 19, column 8)		10,318

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **7,487** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **40,515**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **N/A** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,290**

(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 fo
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **594**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	106,616	10,661	0	117,277	0	117,277	3,369	120,646
2. Food Purchase	0	100,470	0	100,470	0	100,470	-1,274	99,196
3. Housekeeping	66,553	13,283	0	79,836	0	79,836	22	79,858
4. Laundry	35,735	6,394	0	42,129	0	42,129	0	42,129
5. Heat and Other Utilities	0	0	61,556	61,556	0	61,556	220	61,776
6. Maintenance	31,187	6,388	16,236	53,811	0	53,811	1,374	55,185
7. Other (specify)*	0	0	0	0	0	0	768	768
8. Total General Services	240,091	137,196	77,792	455,079	0	455,079	4,479	459,558
9. Medical Director	0	0	16,125	16,125	0	16,125	0	16,125
10. Nursing & Medical Records	737,702	50,457	14,528	802,687	0	802,687	34	802,721
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	25,935	1,301	110	27,346	0	27,346	-594	26,752
12. Social Services	34,378	37	0	34,415	0	34,415	0	34,415
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	798,015	51,795	30,763	880,573	0	880,573	-560	880,013
17. Administrative	0	0	151,000	151,000	0	151,000	-85,778	65,222
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,634	5,634	0	5,634	4,684	10,318
20. Fees, Subscriptions & Promotion	0	0	3,685	3,685	0	3,685	271	3,956
21. Clerical & General Office	35,263	2,059	7,649	44,971	0	44,971	31,442	76,413
22. Employee Benefits & Payroll	0	0	188,471	188,471	0	188,471	0	188,471
23. Inservice Training & Education	0	0	0	0	0	0	112	112
24. Travel and Seminar	0	0	0	0	0	0	33	33
25. Other Admin. Staff Trans	0	0	5,669	5,669	0	5,669	3,112	8,781
26. Insurance-Prop.Liab.Malpractice	0	0	31,761	31,761	0	31,761	781	32,542
27. Other (specify)*	0	0	0	0	0	0	12,766	12,766
28. Total General Adminis	35,263	2,059	393,869	431,191	0	431,191	-32,577	398,614
29. Total General Administrative	1,073,369	191,050	502,424	1,766,843	0	1,766,843	-28,658	1,738,185
30. Depreciation	0	0	107,542	107,542	0	107,542	-17,052	90,490
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	7,237	7,237	0	7,237	21,840	29,077
33. Real Estate	0	0	8,342	8,342	0	8,342	278	8,620
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	10,072	10,072	0	10,072	492	10,564
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	133,193	133,193	0	133,193	5,558	138,751
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	40,515	40,515	0	40,515	0	40,515
43. Other (specify):*	0	15	10,509	10,524	0	10,524	-10,524	0
44. Total Special Cost Ce	0	15	51,024	51,039	0	51,039	-10,524	40,515
45. Grand Total	1,073,369	191,065	686,641	1,951,075	0	1,951,075	-33,624	1,917,451

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	800	800
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	743,350	743,350
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,862	23,862
7. Other Prepaid Expenses	5,883	5,883
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	6,292	6,292
10. Total current assets	780,187	780,187
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	60,518	60,000
14. Buildings, at Historical Cost	1,532,000	1,539,949
15. Leasehold Improvements, Historical Cost	79,897	83,694
16. Equipment, at Historical Cost	287,939	285,402
17. Accumulated Depreciation (book methods)	-543,646	-456,140
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,416,708	1,512,905
25. Total Assets	2,196,895	2,293,092
CURRENT LIABILITIES		
26. Accounts Payable	2,554,838	2,554,838
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	60,801	60,801
31. Accrued Taxes Payable	5,924	5,924
32. Accrued Real Estate Taxes	23,760	23,760
33. Accrued Interest Payable	602	602
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	12,791	12,791
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,658,716	2,658,716
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	96,755	96,755
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	96,755	96,755
46.Total Liabilities	2,755,471	2,755,471
47.Total Equity	-558,576	-462,379
48.Total Liabilities and Equity	2,196,895	2,293,092

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,867,313
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,867,313
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,290
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	1,290
24. Contributions	0
25. Interest and Other Investments Income	1,417
Subtotal - Non-Operating Revenue	1,417
27. Other Revenue (specify):	0
28. Other Revenue (specify):	607
Subtotal - Other Revenue	607
30. Total Revenue	1,870,627
31. General Services	387,587
32. Health Care	703,025
33. General Administration	311,408
34. Ownership	122,752
35. Special Cost Centers	13,885
35. Provider Participation Fee	40,515
37. Other	0
40. Total Expenses	1,579,172
41. Income Before Income Taxes	291,455
42. Income Taxes	0
43. Net Income or Loss for the Year	291,455