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.

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

I. IDPH License ID Number: 0049866

Facility Name: Rock Island Nursing And 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: 03/06/97

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 01/01/11 to 12/31/11 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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,266		3,761	5,027	8
9	SNF/PED					9
10	ICF	38,339	1,915		40,254	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,605	1,915	3,761	45,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.09%

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 2,963

Medicare Intermediary CGS Administrators

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	206,823	91,555	39,849	338,227		338,227	(16,298)	321,929			1
2	Food Purchase		237,145		237,145	(16,556)	220,589	(100)	220,489			2
3	Housekeeping	167,910	55,244		223,154		223,154	(469)	222,685			3
4	Laundry	84,399	34,616	10,740	129,755		129,755	(7)	129,748			4
5	Heat and Other Utilities			166,259	166,259		166,259	(18,905)	147,354			5
6	Maintenance	59,655	40,235	144,177	244,067		244,067	(5,330)	238,737			6
7	Other (specify):*							2,847	2,847			7
8	**TOTAL General Services**	518,787	458,795	361,025	1,338,607	(16,556)	1,322,051	(38,263)	1,283,788			8
	B. Health Care and Programs											
9	Medical Director			41,300	41,300		41,300		41,300			9
10	Nursing and Medical Records	2,027,463	216,878	50,846	2,295,187		2,295,187	(44,412)	2,250,775			10
10a	Therapy	105,336		61,843	167,179		167,179	(12,958)	154,221			10a
11	Activities	99,188	15,147		114,335		114,335		114,335			11
12	Social Services	151,545		4,757	156,302		156,302		156,302			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,098	4,098			15
16	**TOTAL Health Care and Programs**	2,383,532	232,025	158,746	2,774,303		2,774,303	(53,272)	2,721,031			16
	C. General Administration											
17	Administrative	79,026		307,910	386,936		386,936	(237,361)	149,575			17
18	Directors Fees											18
19	Professional Services			214,570	214,570	(635)	213,935	(124,810)	89,125			19
20	Dues, Fees, Subscriptions & Promotions			47,895	47,895		47,895	(7,002)	40,893			20
21	Clerical & General Office Expenses	111,008	30,201	184,233	325,442		325,442	(44,613)	280,829			21
22	Employee Benefits & Payroll Taxes			440,952	440,952	16,556	457,508		457,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,181	4,181		4,181	(1,514)	2,667			24
25	Other Admin. Staff Transportation			9,581	9,581		9,581	6,475	16,056			25
26	Insurance-Prop.Liab.Malpractice			113,924	113,924		113,924	7,566	121,490			26
27	Other (specify):*							28,850	28,850			27
28	**TOTAL General Administration**	190,034	30,201	1,323,246	1,543,481	15,921	1,559,402	(372,410)	1,186,993			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,092,353	721,021	1,843,017	5,656,391	(635)	5,655,756	(463,945)	5,191,811			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 And Rehab Center #0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			101,738	101,738		101,738	157,009	258,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,162	58,162		58,162	385,768	443,930			32
33	Real Estate Taxes					635	635	110,700	111,335			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(540,000)				34
35	Rent-Equipment & Vehicles			6,290	6,290		6,290	4,712	11,002			35
36	Other (specify):*							22,787	22,787			36
37	TOTAL Ownership			706,190	706,190	635	706,825	140,976	847,801			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	128,474	277,801	369,015	775,290		775,290		775,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,908	267,908		267,908		267,908			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	128,474	277,801	636,923	1,043,198		1,043,198		1,043,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,220,827	998,822	3,186,130	7,405,779		7,405,779	(322,968)	7,082,811			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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(20,655)	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	(8,195)	30		9
10	Interest and Other Investment Income	(1,096)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(100)	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				18
19	Entertainment				19
20	Contributions	(850)	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	(88,764)	21		24
25	Fund Raising, Advertising and Promotional	(6,689)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,722)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,572)		$	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)	(141,396)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (141,396)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (322,968)		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 And Rehab Center

ID# 0049866

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 5,363	06	1
2	Capitalized R&M	(5,336)	06	2
3	Bank Fees	(5,907)	21	3
4	Theft & Damage	(672)	21	4
5	Cost Report Settlement	(164)	21	5
6	Collections	(3,152)	21	6
7	Non-Allowable Legal	(8,489)	19	7
8	Non-Allowable Seminar	(1,984)	24	8
9	Amortization - Building Company	(5,358)	36	9
10	Fees - Building Company	(250)	21	10
11	Office Expense - Building Company	(25)	21	11
12	Professional Fees - Building Company	(13,620)	19	12
13	Additional R&M - Building Company	8,451	06	13
14	Capitalized R&M - Building Company	(18,330)	06	14
15	Secretary of State Fee	(250)	20	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**	(49,722)		49

Rock Island Nursing And Rehab Center

ID# 0049866

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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 And Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(16,298)								(16,298)	1
2	Food Purchase	(100)											(100)	2
3	Housekeeping						(469)						(469)	3
4	Laundry						(7)						(7)	4
5	Heat and Other Utilities	(20,655)			1,750								(18,905)	5
6	Maintenance	(9,852)	18,330	(14,049)	241								(5,330)	6
7	Other (specify):*			571	2,276								2,847	7
8	**TOTAL General Services**	(30,607)	18,330	(13,478)	(12,031)		(477)						(38,263)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(31,952)	5,140	(2,700)	(14,900)						(44,412)	10
10a	Therapy				(12,958)								(12,958)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,809	2,289								4,098	15
16	**TOTAL Health Care and Programs**			(30,143)	(5,529)	(2,700)	(14,900)						(53,272)	16
	C. General Administration													
17	Administrative			(289,888)	52,527								(237,361)	17
18	Directors Fees													18
19	Professional Services	(22,108)	13,620	(127,213)	10,891								(124,810)	19
20	Fees, Subscriptions & Promotions	(7,789)		787									(7,002)	20
21	Clerical & General Office Expenses	(104,434)	275	59,497	49								(44,613)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,984)		470									(1,514)	24
25	Other Admin. Staff Transportation			6,475									6,475	25
26	Insurance-Prop.Liab.Malpractice		6,506	977	83								7,566	26
27	Other (specify):*			16,990	11,860								28,850	27
28	**TOTAL General Administration**	(136,316)	20,401	(331,905)	75,410								(372,410)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(166,923)	38,731	(375,526)	57,850	(2,700)	(15,377)						(463,945)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,195)	158,744		5,587	874							157,009	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,096)	387,963	(5,917)	4,818								385,768	32
33	Real Estate Taxes		106,305		4,395								110,700	33
34	Rent-Facility & Grounds		(540,000)										(540,000)	34
35	Rent-Equipment & Vehicles			4,712									4,712	35
36	Other (specify):*	(5,358)	28,145										22,787	36
37	TOTAL Ownership	(14,649)	141,157	(1,205)	14,800	874							140,976	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													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(181,572)	179,888	(376,731)	72,650	(1,826)	(15,377)						(322,968)	45

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	$ 540,000	Rock Island Real Estate, LLC	100.00%	$	$ (540,000)	1
2	V	36	Amortization		Rock Island Real Estate, LLC	100.00%	5,358	5,358	2
3	V	30	Depreciation		Rock Island Real Estate, LLC	100.00%	158,744	158,744	3
4	V	21	Fees		Rock Island Real Estate, LLC	100.00%	250	250	4
5	V	32	Interest	286	Rock Island Real Estate, LLC	100.00%	388,249	387,963	5
6	V	36	MIP		Rock Island Real Estate, LLC	100.00%	22,787	22,787	6
7	V	21	Office		Rock Island Real Estate, LLC	100.00%	25	25	7
8	V	19	Professional Fees		Rock Island Real Estate, LLC	100.00%	13,620	13,620	8
9	V	26	Property Insurance		Rock Island Real Estate, LLC	100.00%	6,506	6,506	9
10	V	33	Real Estate Taxes	3,695	Rock Island Real Estate, LLC	100.00%	110,000	106,305	10
11	V	06	Repairs		Rock Island Real Estate, LLC		18,330	18,330	11
12	V								12
13	V								13
14	Total			$ 543,981			$ 723,869	$ * 179,888	14

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	$ 21,240	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,191	$ (14,049)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	571	571	16
17	V	10	NURSING	42,480	S.I.R. MANAGEMENT, INC.	100.00%	10,528	(31,952)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,809	1,809	18
19	V	19	PROFESSIONAL FEES	135,828	S.I.R. MANAGEMENT, INC.	100.00%	8,615	(127,213)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	787	787	20
21	V	21	CLERICAL & GENERAL	42,480	S.I.R. MANAGEMENT, INC.	100.00%	35,422	(7,058)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	470	470	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,475	6,475	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	977	977	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,106	3,106	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(5,917)	(5,917)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,712	4,712	27
28	V								28
29	V	17	ADMINISTRATIVE	307,910	S.I.R. MANAGEMENT, INC.	100.00%	18,022	(289,888)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,294		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	66,555	66,555	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,884	13,884	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 549,938			$ 174,501	$ * (376,731)	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 21,240	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,942	$ (16,298)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	859	859	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,140	5,140	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	890	890	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	52,527	52,527	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,218	10,218	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,860	11,860	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,240	S.I.R. MANAGEMENT, INC.	100.00%	8,282	(12,958)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,399	1,399	25
26	V								26
27	V	6	MAINTENANCE SALARIES	7,544	S.I.R. MANAGEMENT, INC.	100.00%	7,069	(475)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,417	1,417	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,750	1,750	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	716	716	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	38	38	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	49	49	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	83	83	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,587	5,587	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,818	4,818	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,395	4,395	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	635	635	38
39	Total			$ 50,024			$ 122,674	$ * 72,650	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	10	RESPITORY CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	(2,700)	$ (2,700)	15
16	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	874	874	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			$			$ (1,826)	$ * (1,826)	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	7,739	Xcel Supply, LLC	100.00%	7,270	(469)	16
17	V	4	Laundry	122	Xcel Supply, LLC	100.00%	114	(7)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	245,781	Xcel Supply, LLC	100.00%	230,881	(14,900)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	32	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 253,642			$ 238,266	$ * (15,377)	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 117,026	$ 117,026	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	117,026	CCS Employee Benefits Group	100.00%		(117,026)	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			$ 117,026			$ 117,026	$ *	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	ATIED ASSOCIATES	28.437%	ALBANY CARE INC	EVANSTON	ROCK ISLAND REAL ESTATE, L	LINCOLNWOOD	BUILDING CO.	1
2	B.G. TRUST	4.739%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BARRIS GROUP LIMITED PARTNERSHIP	9.479%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	9.479%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	4
5	FAY CHIN	1.130%	ELMWOOD CARE, INC.	ELMWOOD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	JEFF ORAVEC	1.130%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	KIM SHELTON	1.130%	GREENWOOD CARE, INC.	EVANSTON				7
8	L.G. TRUST	4.739%	MAPLEWOOD CARE, INC.	ELGIN				8
9	LOUISE BERGTHOLD	1.130%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	LYNN ETHELL	1.130%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	NENITA GUZMAN	1.130%	WILSON CARE, INC.	CHICAGO				11
12	PATRICIA MCDIARMID	1.130%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	RALPH GESUALDO	9.479%						13
14	RALPH GESUALDO CHILDREN'S TRUST	9.479%						14
15	RONALD NUNZIATO, JR.	1.130%						15
16	THOMAS WINTER	5.650%						16
17	UNITED TRUST #1	4.739%						17
18	UNITED TRUST #2	4.739%						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 Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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								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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Eric Rothner	Relative	Administrative	N/A	See Attached	0.32	0.69%	Alloc. Salary	$ 7,369	17-7	1
2	Bryan Barrish	Shareholder	Administrative	9.48	See Attached	2.16	4.80%	Alloc. Salary	10,812	17-7	2
3	Michael Giannini	Relative	Administrative	N/A	See Attached	1.89	4.73%	Alloc. Salary	9,028	17-7	3
4	Nenita Guzman	Shareholder	Dietary	1.13	See Attached	2.7	5.40%	Alloc. Salary	4,942	1-7	4
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	2.7	5.40%	Alloc. Salary	6,473	17-7	5
6	Kirsten Barrish	Relative	Clerical	N/A	See Attached	2.16	5.40%	Alloc. Salary	2,434	21-7	6
7	Andrew Chin	Relative	Clerical	N/A	See Attached	2.16	5.40%	Alloc. Salary	3,889	21-7	7
8	Fay Chin	Shareholder	Nursing	1.13	See Attached	2.16	5.40%	Alloc. Salary	5,140	10-7	8
9	Jeff Oravec	Shareholder	Administrative	1.13	See Attached	2.16	5.40%	Alloc. Salary	7,209	17-7	9
10	Kim Shelton	Shareholder	Clerical	1.13	See Attached	2.16	5.40%	Alloc. Salary	3,706	21-7	10
11	Louise Bergthold	Shareholder	Administrative	1.13	See Attached	0.65	1.08%	Alloc. Salary	2,271	17-7	11
12	See second page 7 for the detail of the additional owner and related compensation								31,622		12
13								TOTAL	$ 94,895		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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	837,569	13	$ 133,007	$ 59,965	45,281	$ 7,191	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		45,281	571	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	45,281	10,528	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		45,281	1,809	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	45,281	8,615	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		45,281	787	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	45,281	35,422	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		45,281	470	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		45,281	6,475	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		45,281	977	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		45,281	3,106	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		45,281	(5,917)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		45,281	4,712	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	45,281	18,022	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		45,281	1,294	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	45,281	66,555	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		45,281	13,884	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,227,764	$ 2,435,627		$ 174,501	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	837,569	13	$ 91,408	$ 91,408	45,281	$ 4,942	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		45,281	859	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	45,281	5,140	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		45,281	890	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	45,281	52,527	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		45,281	10,218	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		45,281	11,860	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	21,240	8,282	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		21,240	1,399	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	7,544	7,069	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		7,544	1,417	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		696	1,750	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		696	716	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		696	38	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		696	49	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		696	83	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		696	5,587	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		696	4,818	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		696	4,395	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		696	635	24
25	TOTALS					$ 2,490,426	$ 1,625,498		$ 122,674	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	10	RESPITORY CONSULTANT	LEASING INCOME	100	2	(27,000)		10	(2,700)	1
2	30	DEPRECIATION	LEASING INCOME	100	2	8,739		10	874	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					$	$		$ (1,826)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$	1
2	3	Housekeeping	Direct Allocation						7,270	2
3	4	Laundry	Direct Allocation						114	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						230,881	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	32	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation							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					$	$		$ 238,266	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 117,026	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					$	$		$ 117,026	25

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$ 5,141,900			$ 254,035	1
2	Other		X								134,214	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				1,300,000			58,162	6
7	Shareholder Loan		X					100,000				7
8	See Supplemental Schedule										4,818	8
9	TOTAL Facility Related						$	$ 6,541,900			$ 451,229	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,096)	10
11	Interest Income - Bldg. Co.		X								(286)	11
12	Allocated from SIR Mgmt		X								(5,917)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (7,300)	14
15	TOTALS (line 9+line14)						$	$ 6,541,900			$ 443,930	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 22,787 **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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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				$	$			$ 4,818	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,818	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 And Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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.**	$ 108,575	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.)		$ 109,275	2
3. Under or (over) accrual (line 2 minus line 1).		$ 700	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,000	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.**		$ 635	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.		$ 111,335	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	136,536	8
	2007	123,279	9
	2008	124,475	10
	2009	103,404	11
	2010	104,880	12

Accrual = $104,880 x 1.05 = $110,000

Allocation from SIR Management = $4,395

	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 Rock Island Nursing And 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 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.	10-341-78-00	Long Term Care Property	$ 103,407.52	$ 103,407.52
2.	10-341-79-00	Long Term Care Property	$ 1,472.84	$ 1,472.84
3.	See Attached	See Attached	$ 98,193.53	$ 4,155.51
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 203,073.89	$ 109,035.87

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 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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Island Nursing And Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	177			1975	$ 3,579,244	$ 158,744	39	$ 92,208	$ (66,536)	$ 1,317,849	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	396	396	3,591	9
10	Various			2003	5,954		20	216	216	1,749	10
11	Various			2004	9,240		20	336	336	2,534	11
12	Various			2005	48,760		20	2,139	2,139	13,816	12
13	Various			2006	39,068		20	1,421	1,421	8,201	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

*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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
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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)		206,007			12,455	12,455	88,647	67
68	Related Party Allocations (Pages 12H & 12I)		81,381	2,542		3,620	1,078	34,946	68
69	Financial Statement Depreciation			101,738			(101,738)		69
70	TOTAL (lines 4 thru 69)		$ 3,980,541	$ 263,024		$ 112,791	$ (150,233)	$ 1,471,333	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Totals from Page 12A, Carried Forward		$ 3,980,541	$ 263,024		$ 112,791	$ (150,233)	$ 1,471,333	1
2	Nurse Station	2008	19,200		20	1,920	1,920	6,560	2
3	Floor Work	2008	75,693		20	7,569	7,569	25,862	3
4	Ceiling Tile	2008	35,437		20	3,544	3,544	13,289	4
5	Draperies	2008	42,557		20	8,511	8,511	28,371	5
6	Painting	2008	226,884		20	22,688	22,688	75,628	6
7	Doors	2008	3,291		20	329	329	1,015	7
8	Compressor	2008	5,717		20	1,143	1,143	3,907	8
9	Crash Guards	2008	55,423		20	5,542	5,542	18,012	9
10	Flooring	2008	57,770		20	8,425	8,425	8,425	10
11	A/C Units	2008	4,386		20	219	219	768	11
12	Heat / Cool Units	2008	2,632		20	132	132	439	12
13	Signage	2009	3,992		20	399	399	1,198	13
14	Bath/Shower Room	2009	4,175		20	209	209	609	14
15	Flooring	2009	20,323		20	1,016	1,016	2,964	15
16	Beauty Shop- Flooring, Wood Blinds, Furnishings	2009	11,709		20	1,171	1,171	3,415	16
17	Beauty Shop/Office- Construction, Wall Work, Paint	2009	12,195		20	610	610	1,778	17
18	Firestopping	2009	28,918		20	1,446	1,446	4,097	18
19	Flooring	2009	3,205		20	160	160	454	19
20	Baseboard	2009	8,633		20	432	432	1,187	20
21	Generator	2009	64,744		20	3,237	3,237	8,633	21
22	Exterior Sign	2009	10,344		20	517	517	1,379	22
23	Generator Panel	2009	4,320		20	216	216	576	23
24	Emergency Panel	2009	7,465		20	373	373	964	24
25	Wiring Recepticles	2009	5,654		20	283	283	730	25
26	Light Fixtures	2009	2,914		20	291	291	704	26
27	Elevator	2009	15,382		20	769	769	1,795	27
28	Elevator	2009	15,382		20	769	769	1,795	28
29	Doors	2009	3,108		20	311	311	725	29
30	Doors & Hardware	2009	8,587		20	859	859	2,004	30
31	Closet Doors	2009	7,225		20	723	723	1,686	31
32	Doors	2009	3,186		20	319	319	717	32
33	Doors	2009	2,630		20	263	263	592	33
34	TOTAL (lines 1 thru 33)		$ 4,753,622	$ 263,024		$ 187,186	$ (75,838)	$ 1,691,608	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Totals from Page 12B, Carried Forward		$ 4,753,622	$ 263,024		$ 187,186	$ (75,838)	$ 1,691,608	1
2	Chiller Unit	2009	5,092		20	255	255	637	2
3	Compressor	2009	5,032		20	252	252	608	3
4	Lighting	2009	4,915		20	246	246	573	4
5	Lighting	2009	6,395		20	320	320	719	5
6	Wiring In Elevator	2009	3,474		20	174	174	376	6
7	Asphalt-Parking Lot	2009	5,475		20	274	274	570	7
8	Rofftop Motors	2009	3,995		20	200	200	416	8
9	Electric Work	2009	2,501		20	250	250	521	9
10	Added 3 Voice And Data Runs	2009	2,649		20	132	132	276	10
11	Receptacles	2010	8,185		20	1,637	1,637	1,773	11
12	Chiller Conduit	2010	5,557		20	278	278	509	12
13	12 Volt Circuit	2010	3,738		20	187	187	343	13
14	Door Alarm Repair	2010	4,190		20	210	210	367	14
15	Compressor	2011	5,038		20	147	147	147	15
16	Security Camera System	2011	8,917		20	223	223	223	16
17	Hair Salon Door	2011	3,120		20	52	52	52	17
18	Door Locks And Alarms Repair	2011	2,669		20	133	133	133	18
19	Compressor Repair	2011	2,666		20	13	13	13	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)		$ 4,837,231	$ 263,024		$ 192,167	$ (70,857)	$ 1,699,866	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Totals from Page 12C, Carried Forward		$ 4,837,231	$ 263,024		$ 192,167	$ (70,857)	$ 1,699,866	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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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)		$ 4,837,231	$ 263,024		$ 192,167	$ (70,857)	$ 1,699,866	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Totals from Page 12D, Carried Forward		$ 4,837,231	$ 263,024		$ 192,167	$ (70,857)	$ 1,699,866	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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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)		$ 4,837,231	$ 263,024		$ 192,167	$ (70,857)	$ 1,699,866	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Building Company Information								1
2	Buildings:								2
3									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	32,917	9
10	Windows	1998	2,278		20	114	114	1,063	10
11	Walk-In Freezer Compressor	2000	2,097		20	1,095	1,095	1,048	11
12	Electrical Work	2001	1,854		20	93	93	848	12
13	Water Heater	2008	6,570		20	329	329	2,961	13
14	Handrails	2008	100,904		20	5,045	5,045	45,405	14
15	Electrical Work - Resident Rooms	2010	7,985		20	399	399	798	15
16	Wall Removal - 4th Floor Dining	2010	8,100		20	405	405	810	16
17	Outdoor Fence	2010	6,570		20	329	329	658	17
18	Kitchen Lighting	2010	8,026		20	803	803	1,606	18
19	Flooring - Carpet and Tile	2011	7,869		20	393	393	393	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	140	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 206,007	$		$ 12,455	$ 12,455	$ 88,647	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from SIR Properties - SIR Management	1993	24,461	777	20	699	(78)	12,230	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management	1993	6,202	173	20	307	134	5,841	9
10	Allocated from SIR Management	1994	19		20			19	10
11	Allocated from SIR Management	1995	142		20	7	7	116	11
12	Allocated from SIR Management	1997	9,529	213	20	467	254	7,047	12
13	Allocated from SIR Management	1999	749		20	38	38	459	13
14	Allocated from SIR Management	2000	885		20	44	44	510	14
15	Allocated from SIR Management	2007	2,842	262	20	142	(120)	596	15
16	Allocated from SIR Management	2008	7,833	748	20	494	(254)	1,898	16
17	Allocated from SIR Management	2009	19,465	178	20	973	795	2,184	17
18	Allocated from SIR Management	2011	482	20	20	10	(10)	10	18
19									19
20									20
21	Allocated from SIR Properties - SIR Management	2010	1,476		20	74	74	98	21
22	Allocated from SIR Properties - SIR Management	2009	1,469	128	20	73	(55)	206	22
23	Allocated from SIR Properties - SIR Management	2007	428	35	20	21	(14)	107	23
24	Allocated from SIR Properties - SIR Management	2002	97		20	5	5	46	24
25	Allocated from SIR Properties - SIR Management	1999	3,099		20	155	155	1,937	25
26	Allocated from SIR Properties - SIR Management	1998	1,481		20	74	74	1,000	26
27	Allocated from SIR Properties - SIR Management	1997	92		20	5	5	71	27
28	Allocated from SIR Properties - SIR Management	1994	233	6	20	12	6	204	28
29	Allocated from SIR Properties - SIR Management	1993	397	2	20	20	18	367	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 81,381	$ 2,542		$ 3,620	$ 1,078	$ 34,946	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 637,115	$ 2,804	$ 60,076	$ 57,272	10	$ 451,516	71
72	Current Year Purchases	80,575	880	6,222	5,342	10	11,281	72
73	Fully Depreciated Assets	21,463		12	12	10	21,463	73
74								74
75	TOTALS	$ 739,153	$ 3,684	$ 66,310	$ 62,626		$ 484,260	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	Facility	Allocated from SIR Mgmt	2011	$ 1,900	$ 234	$ 269	$ 35	5	$ 376	76
77										77
78										78
79										79
80	TOTALS			$ 1,900	$ 234	$ 269	$ 35		$ 376	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)	$ 5,998,284	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 266,942	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,747	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,195)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,184,502	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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:				$			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: $ 11,002 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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	39 - 03	hrs	$		$ 145,681	$		$ 145,681	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			53,804			53,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			169,530			169,530	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				165,831		165,831	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			128,474			111,970		240,444	13
14	TOTAL			$ 128,474		$ 369,015	$ 277,801		$ 775,290	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 112,932	$ 117,538	1
2	Cash-Patient Deposits	35,866	35,866	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,020,639	2,020,639	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,222	60,239	6
7	Other Prepaid Expenses	1,494	1,494	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	4,778	763,367	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,209,931	$ 2,999,143	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	740,510	878,665	15
16	Equipment, at Historical Cost	513,260	552,270	16
17	Accumulated Depreciation (book methods)	(332,341)	4,848,178	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,810)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		77,473	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 921,429	$ 6,360,495	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,131,360	$ 9,359,638	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,758	$ 201,757	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,870	35,870	28
29	Short-Term Notes Payable	1,400,000	1,400,000	29
30	Accrued Salaries Payable	202,582	202,582	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,419	23,419	31
32	Accrued Real Estate Taxes(Sch.IX-B)		110,000	32
33	Accrued Interest Payable		15,383	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,000	8,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	393,950	393,950	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,265,579	$ 2,390,961	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,141,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		215	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,142,115	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,265,579	$ 7,533,076	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 865,781	$ 1,826,562	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,131,360	$ 9,359,638	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 401,620	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 401,621	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	393,360	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	70,800	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 464,160	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)**	$ 865,781	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 7,349,969	1
2	Discounts and Allowances for all Levels	(1,284,879)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,065,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,357,768	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,357,768	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	137,163	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,811	19
20	Radiology and X-Ray	354	20
21	Other Medical Services	221,857	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 375,185	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,096	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,096	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)**	$ 7,799,139	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,338,607	31
32	Health Care	2,774,303	32
33	General Administration	1,543,481	33
	B. Capital Expense		
34	Ownership	706,190	34
	C. Ancillary Expense		
35	Special Cost Centers	775,290	35
36	Provider Participation Fee	267,908	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,405,779	40
41	**Income before Income Taxes (line 30 minus line 40)****	393,360	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 393,360	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 And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,013	2,166	$ 66,814	$ 30.85	1
2	Assistant Director of Nursing	1,994	2,171	53,905	24.83	2
3	Registered Nurses	6,035	6,395	153,677	24.03	3
4	Licensed Practical Nurses	35,359	38,106	718,813	18.86	4
5	CNAs & Orderlies	79,675	79,701	846,122	10.62	5
6	CNA Trainees					6
7	Licensed Therapist	5,065	5,142	128,474	24.99	7
8	Rehab/Therapy Aides	7,636	8,140	105,336	12.94	8
9	Activity Director	2,005	2,086	31,007	14.86	9
10	Activity Assistants	6,126	6,514	68,181	10.47	10
11	Social Service Workers	11,321	12,039	151,545	12.59	11
12	Dietician					12
13	Food Service Supervisor	2,059	2,131	36,301	17.03	13
14	Head Cook	6,101	6,428	61,738	9.60	14
15	Cook Helpers/Assistants	12,854	12,897	108,784	8.43	15
16	Dishwashers					16
17	Maintenance Workers	4,258	4,441	59,655	13.43	17
18	Housekeepers	17,144	17,920	167,910	9.37	18
19	Laundry	8,805	9,278	84,399	9.10	19
20	Administrator	1,949	2,086	79,026	37.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,051	8,437	111,008	13.16	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	5,990	6,442	110,149	17.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,434	6,908	77,983	11.29	33
34	TOTAL (lines 1 - 33)	230,874	239,428	$ 3,220,827 *	$ 13.45	34

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	$ 18,609	01-03	35
36	Medical Director	Monthly	41,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,480	10-03	38
39	Pharmacist Consultant	Monthly	8,366	10-03	39
40	Physical Therapy Consultant	303	18,095	10a-03	40
41	Occupational Therapy Consultant	257	15,368	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	115	7,140	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	76	4,757	12-03	45
46	Other(specify)				46
47	Specialized Services	Monthly	21,240	10a-03	47
48	Director of Food Services	Monthly	21,240	01-03	48
49	TOTAL (lines 35 - 48)	751	$ 198,595		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

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

** See instructions.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn May	Administrator	0.00%	$ 79,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,026

B. Administrative - Other

Description	Amount
SIR Management - Director of Administrative Services	$ 42,480
SIR Management - Ancillary Administrative Charges	42,480
SIR Management - Consulting Fee	222,950
TOTAL (agree to Schedule V, line 17, col. 3)	$ 307,910
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Data Processing	$ 3,600
Pinnacle	Customer Satisfaction	2,646
American Data	Data Processing	4,739
Honkamp Krueger	Tax Credit Report	5,067
HDSI	Program Services	446
Compliance Team	Accreditation Services	769
See Attached	Legal	39,154
SIR Management	Dir of Regulatory Services	21,240
SIR Management	Bookkeeping Fees	78,588
SIR Management	Accounting Fees	36,000
Frost, Ruttenberg, & Rothblatt	Accounting Fees	20,050
See Supplemetal Schedule		2,271
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 214,570

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,525
Unemployment Compensation Insurance	43,998
FICA Taxes	242,097
Employee Health Insurance	66,365
Employee Meals	16,556
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,967
TOTAL (agree to Schedule V, line 22, col.8)	$ 457,508

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	$ 1,244
Advertising: Employee Recruitment	
Health Care Worker Background Check	15,540
(Indicate # of checks performed 527)	5,272
Patient Background Checks 102	1,020
Licenses & Permits	550
Dues & Subscriptions	16,480
Advertising & Promotions	6,689
Allocated from SIR Management	787
Less: Public Relations Expense	( )
Non-allowable advertising	(6,689)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,893

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,197
Allocated from SIR Management	470
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,667

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 And Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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 - $15,057.85**

(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. $ **1,049** 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 **Yes** 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. $ **267,908**
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. $ **16,556** 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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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.

SEE ACCOUNTANTS' COMPILATION REPORT