

		FOR BHF USE			

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

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

<p>I. IDPH License ID Number: <u>0047548</u></p> <p>Facility Name: <u>Rosiclare Rehabilitation & Health Care Center</u></p> <p>Address: <u>Route 1 Box 55A</u> <u>Rosiclare</u> <u>62982</u> Number City Zip Code</p> <p>County: <u>Hardin</u></p> <p>Telephone Number: <u>(618) 285-3655</u> Fax # <u>(618) 285-6667</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/01/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%;"> <tr> <td style="width:33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 689-5869</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Mark B. Petersen</u>		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,972	2,223	2,223	16,418	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,972	2,223	2,223	16,418	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.55%

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 2,218

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center # 0047548 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	98,833	10,025	320	109,178		109,178	3,312	112,490		1
2	Food Purchase		85,386		85,386		85,386	(3,260)	82,126		2
3	Housekeeping	69,713	13,618		83,331		83,331	21	83,352		3
4	Laundry	17,618	6,599		24,217		24,217		24,217		4
5	Heat and Other Utilities			60,615	60,615		60,615	217	60,832		5
6	Maintenance	27,304	7,548	13,452	48,304		48,304	1,350	49,654		6
7	Other (specify):* Home Off. Ben. All.							755	755		7
8	TOTAL General Services	213,468	123,176	74,387	411,031		411,031	2,395	413,426		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	661,274	61,911	7,685	730,870		730,870	33	730,903		10
10a	Therapy		53	387,229	387,282		387,282		387,282		10a
11	Activities	37,091		132	37,223		37,223	(8,582)	28,641		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	698,365	61,964	399,846	1,160,175		1,160,175	(8,549)	1,151,626		16
	C. General Administration										
17	Administrative			276,200	276,200		276,200	(206,032)	70,168		17
18	Directors Fees										18
19	Professional Services			4,095	4,095		4,095	4,569	8,664		19
20	Dues, Fees, Subscriptions & Promotions			1,180	1,180		1,180	266	1,446		20
21	Clerical & General Office Expenses	30,037	2,634	6,431	39,102		39,102	31,138	70,240		21
22	Employee Benefits & Payroll Taxes			108,506	108,506		108,506		108,506		22
23	Inservice Training & Education							110	110		23
24	Travel and Seminar							33	33		24
25	Other Admin. Staff Transportation			8,769	8,769		8,769	2,837	11,606		25
26	Insurance-Prop.Liab.Malpractice			20,706	20,706		20,706	768	21,474		26
27	Other (specify):* Home Off. Ben. All.							12,550	12,550		27
28	TOTAL General Administration	30,037	2,634	425,887	458,558		458,558	(153,761)	304,797		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	941,870	187,774	900,120	2,029,764		2,029,764	(159,915)	1,869,849		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Rosiclare Rehabilitation & Health Care Center

#0047548

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			99,331	99,331		99,331	4,375	103,706			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,031	176,031		176,031	36,183	212,214			32
33	Real Estate Taxes			5,592	5,592		5,592	273	5,865			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,143	21,143		21,143	484	21,627			35
36	Other (specify):*											36
37	TOTAL Ownership			302,097	302,097		302,097	41,315	343,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,971		93,971		93,971		93,971			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,945	33,945		33,945		33,945			42
43	Other (specify):* <i>Non-allowable Costs</i>		393	76,011	76,404		76,404	(76,404)				43
44	TOTAL Special Cost Centers		94,364	109,956	204,320		204,320	(76,404)	127,916			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	941,870	282,138	1,312,173	2,536,181		2,536,181	(195,004)	2,341,177			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,275)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,927)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(194)	30		9
10	Interest and Other Investment Income	(49)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,664)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,524)	43		24
25	Fund Raising, Advertising and Promotional	(3,982)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(17,475)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,292)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(105,712)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,712)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (195,004)		37

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

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

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

Rosiclare Rehabilitation & Health Care Center

ID# 0047548

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,065)	43	1
2	X-Rays-Part A	(1,850)	43	2
3	Offset Transportation Revenue	(8,582)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(788)	21	4
5	Disallowed Special Events	(190)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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44				44
45				45
46				46
47				47
48				48
49	Total	(17,475)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,312	\$ 3,312	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	15	15	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	217	217	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,350	1,350	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	755	755	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	33	33	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	276,200	Petersen Health Care, Inc.	100.00%	70,168	(206,032)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,789	3,789	12
13	V							13
14	Total		\$ 276,200			\$ 79,660	\$ * (196,540)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 266	\$ 266	15	
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	30,877	30,877	16	
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	110	110	17	
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	33	33	18	
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,837	2,837	19	
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	768	768	20	
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,550	12,550	21	
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,436	4,436	22	
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,340	5,340	23	
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	273	273	24	
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25	
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	484	484	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		\$			\$ 57,974	\$ *	57,974	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	780	780	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,049	1,049	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	133	133	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	30,892	30,892	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 32,854	\$ *	32,854	39

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

Facility Name & ID Number

Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				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

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

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

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

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,542,131	77	\$ 311,109	\$ 308,619	16,418	\$ 3,312	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	16,418	15	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	16,418	21	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	16,418	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	16,418	217	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	16,418	1,350	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	16,418	755	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	16,418	33	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	16,418	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	16,418	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	16,418	70,168	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	16,418	3,789	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	16,418	266	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	16,418	30,877	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	16,418	110	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	16,418	33	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	16,418	2,837	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	16,418	768	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	16,418	12,550	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	16,418	4,436	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	16,418	5,340	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	16,418	273	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	16,418	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	16,418	484	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 137,634	25

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	402,040	21	\$	\$	16,418	\$	1
2	2	Food	Resident Days	402,040	21			16,418		2
3	3	Housekeeping	Resident Days	402,040	21			16,418		3
4	4	Laundry	Resident Days	402,040	21			16,418		4
5	5	Utilities	Resident Days	402,040	21			16,418		5
6	6	Maintenance	Resident Days	402,040	21			16,418		6
7	7	Mgmt. Allocation of Benefits	Resident Days	402,040	21			16,418		7
8	10	Nursing and Medical Records	Resident Days	402,040	21			16,418		8
9	12	Social Services	Resident Days	402,040	21			16,418		9
10	17	Administrative	Resident Days	402,040	21			16,418		10
11	19	Professional Services	Resident Days	402,040	21	19,096		16,418	780	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	402,040	21			16,418		12
13	21	Clerical and General Office	Resident Days	402,040	21	25,677		16,418	1,049	13
14	22	Employee Benefits & Payroll	Resident Days	402,040	21			16,418		14
15	23	Inservice Training & Education	Resident Days	402,040	21			16,418		15
16	24	Travel and Seminar	Resident Days	402,040	21			16,418		16
17	25	Other Admin. Staff Transport.	Resident Days	402,040	21			16,418		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	402,040	21			16,418		18
19	27	Mgmt. Allocation of Benefits	Resident Days	402,040	21			16,418		19
20	30	Depreciation	Resident Days	402,040	21	3,263		16,418	133	20
21	32	Interest	Resident Days	402,040	21	756,464		16,418	30,892	21
22	33	Real Estate Taxes	Resident Days	402,040	21			16,418		22
23	34	Rent-Facility and Grounds	Resident Days	402,040	21			16,418		23
24	35	Rent-Equipment & Vehicles	Resident Days	402,040	21			16,418		24
25	TOTALS					\$ 804,500	\$		\$ 32,854	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10			
										Related**		Purpose of Loan
Name of Lender	YES	NO	Original	Balance								
A. Directly Facility Related												
Long-Term												
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 3,500,000	\$ 3,315,491	12/31/13	Varies	\$ 176,031	1
2												2
3							Interest Income Offset				(49)	3
4							Home Office Allocation-PHC				5,340	4
5							Home Office Allocation-PHO				30,892	5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,500,000	\$ 3,315,491			\$ 212,214	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,500,000	\$ 3,315,491			\$ 212,214	15

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>				
1. Real Estate Tax accrual used on 2010 report.		\$	5,460	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	\$	5,412	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(48)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	5,640	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	273	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	5,865	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006	4,636		8
	2007	4,934		9
	2008	5,162		10
	2009	5,281		11
	2010	5,412		12
Accrual based on prior year tax bill.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosiclare Rehabilitation & Health Care Center COUNTY Hardin

FACILITY IDPH LICENSE NUMBER 0047548

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-82-001-02-000</u>	<u>Long-Term Care Facility</u>	\$ <u>5,412.48</u>	\$ <u>5,412.48</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>5,412.48</u></u>	\$ <u><u>5,412.48</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,600 B. General Construction Type: Exterior Masonry Frame Metal Number of Stories 1

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

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62	2005	1975	\$ 1,347,250	\$	25	\$ 53,890	\$ 53,890	\$ 350,285	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements		2005	15,000		15	1,000	1,000	6,500	9
10	Sidewalks		2006	1,600		15	107	107	588	10
11	Sidewalks		2007	2,400		15	160	160	720	11
12	Parking Lot Resurfacing		2008	15,063		39	386	386	1,351	12
13	Heat Pump-5-Ton		2008	4,940		5	988	988	3,458	13
14	Sprinkler System Repair		2008	16,695		39	428	428	1,498	14
15	Sprinkler System Repair		2008	14,500		39	372	372	1,302	15
16	Dry Pendant Installation (23)		2008	2,812		20	140	140	490	16
17	Sprinkler System Repair		2009	16,205		7	2,316	2,316	5,790	17
18	Nurse Call System		2010	7,905		10	790	790	1,185	18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28	Land Improvements Booked				1,653			(1,653)		28
29	Building Booked				53,927			(53,927)		29
30	Building Improvement Booked				5,034			(5,034)		30
31										31
32										32
33	2011-Home Office Allocation-Land Improvements			729			47	47		33
34	2011-Home Office Allocation-Building Improvements			7,814			187	187		34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,452,913	60,614	60,811	197	373,167	

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 274,053	\$ 38,717	\$ 38,560	\$ (157)	7-10 yrs.	\$ 248,350	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,335	4,335			74
75	TOTALS	\$ 274,053	\$ 38,717	\$ 42,895	\$ 4,178		\$ 248,350	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,801,216	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,331	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,706	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,375	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 621,517	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

**

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,689

Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

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

**Rosiclare Rehabilitation & Health Care Center
0047548**

Period Beginning

1/1/2011

Period End

12/31/2011

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	8,774
Dishwasher		708
Laundry Equipment		-
Copier		4,723
Home Office Allocation		484
		<u>14,689</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Outside Practitioner (other than consultant)								
					Units	Cost							
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,787	\$	131,806	\$	8,787	\$	131,806	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,758		101,370		6,758		101,370	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,243		153,648		53	10,243	153,701	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39(2)	# of prescripts						93,971		93,971	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): _____											12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			27		405			27	405	13	
14	TOTAL			\$	25,815	\$	387,229	\$	94,024	25,815	\$	481,253	14

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

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,144,526	\$ 4,144,526	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	728,124	728,124	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,474	17,474	6
7	Other Prepaid Expenses	8,794	8,794	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,898,918	\$ 4,898,918	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,250	13
14	Buildings, at Historical Cost	1,455,563	1,355,064	14
15	Leasehold Improvements, at Historical Cost	63,057	97,849	15
16	Equipment, at Historical Cost	274,052	274,053	16
17	Accumulated Depreciation (book methods)	(598,370)	(621,517)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,194,302	\$ 1,179,699	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,093,220	\$ 6,078,617	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 549,946	\$ 549,946	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,357	19,357	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,358	3,358	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,640	5,640	32
33	Accrued Interest Payable	17,351	17,351	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	20,847	20,847	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 616,499	\$ 616,499	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,315,491	3,315,491	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,315,491	\$ 3,315,491	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,931,990	\$ 3,931,990	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,161,230	\$ 2,146,627	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,093,220	\$ 6,078,617	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,070,982	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,070,982	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	90,248	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 90,248	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)	\$ 2,161,230	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,157,686	1
2	Discounts and Allowances for all Levels	(284,504)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,873,182	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	570,083	6
7	Oxygen	6,793	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 576,876	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	3,275	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	146,338	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,518	20
21	Other Medical Services	6,821	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 166,952	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	788	28
28a	Transportation Revenue	8,582	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,370	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,626,429	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	411,031	31
32	Health Care	1,160,175	32
33	General Administration	458,558	33
B. Capital Expense			
34	Ownership	302,097	34
C. Ancillary Expense			
35	Special Cost Centers	170,375	35
36	Provider Participation Fee	33,945	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,536,181	40
41	Income before Income Taxes (line 30 minus line 40)**	90,248	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 90,248	43

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

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

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

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

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,064	2,064	\$ 60,129	\$ 29.13	1
2	Assistant Director of Nursing	1,896	2,064	49,638	24.05	2
3	Registered Nurses	6,000	6,343	129,442	20.41	3
4	Licensed Practical Nurses	8,047	8,320	120,148	14.44	4
5	CNAs & Orderlies	28,824	29,767	263,337	8.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,938	2,064	22,507	10.90	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,064	2,064	28,483	13.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,983	8,410	70,350	8.37	15
16	Dishwashers					16
17	Maintenance Workers	1,949	2,065	27,304	13.22	17
18	Housekeepers	5,165	5,291	69,713	13.18	18
19	Laundry	2,022	2,092	17,618	8.42	19
20	Administrator	2,066	2,066	70,168	33.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,894	2,060	30,037	14.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Care Plan Coord	2,068	2,068	38,580	18.66	32
33	Other(specify) Transportation	1,676	1,738	14,584	8.39	33
34	TOTAL (lines 1 - 33)	75,656	78,476	\$ 1,012,038 *	\$ 12.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	6	\$ 320	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,959	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6	\$ 8,079		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lucinda Spivey	Administrator	0	\$ 70,168	Workers' Compensation Insurance	\$ 18,766	IDPH License Fee	\$	
				Unemployment Compensation Insurance	22,259	Advertising: Employee Recruitment		
				FICA Taxes	70,532	Health Care Worker Background Check		
				Employee Health Insurance	(3,520)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	89 891	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	266	
				Employee Relations	259	Miscellaneous Dues & Subscriptions	23	
				Employee Retirement	123			
				Life Insurance	87	Home Office Allocation	266	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
			\$ 70,168					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 276,200				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				\$ 108,506			\$ 1,446	
			\$ 276,200					
C. Professional Services								
Vendor/Payee	Type	Amount						
E-Health Data Solutions	Computer Services	\$ 3,485						
Shawnee Communications	Computer Services	360						
Honkamp Krueger & Co.	Accounting Fees	250						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 4,095			\$ 33	

* Attach copy of IMRF notifications

**See instructions.

Rosiclare Rehabilitation & Health Care Center

0047548

Period Beginning 1/1/2011

Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,095

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	
Ginoli & Company	Accountants	1,306
Miscellaneous Vendors	Computer Services	42
Advanced Answers on Demand	Computer Services	2,198
Access 2 Go	Computer Services	216
Kemper Technology	Computer Services	101
MediFax	Computer Services	34
VisionShare	Computer Services	155
Advanced System Design	Computer Services	202
Simple LTC	Computer Services	254
Optimizer Systems	Other Prof Fees	26
Clifton Gunderson	Other Prof Fees	9
Mike Miller	Other Prof Fees	12
OIC Group	Other Prof Fees	3
All Scripts	Other Prof Fees	7

Total (agree to Schedule V, line 19, column 8)	<u><u>8,664</u></u>
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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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

0047548

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,311 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,945
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,275
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,166
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees