FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0047530

Facility Name: Rock Falls Rehabilitation & Health Care Center

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

County: Whiteside

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	11,301	1,866		13,167	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,301	1,866		13,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.29%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Independent Living

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

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	112,642	9,191		121,833		121,833	(25,126)	96,707			1
2	Food Purchase		95,260		95,260		95,260	(25,280)	69,980			2
3	Housekeeping	68,878	15,014		83,892		83,892	(18,933)	64,959			3
4	Laundry	28,606	14,444		43,050		43,050	(9,722)	33,328			4
5	Heat and Other Utilities			84,140	84,140		84,140	(18,818)	65,322			5
6	Maintenance	36,368	5,450	19,710	61,528		61,528	(12,570)	48,958			6
7	Other (specify):* Home Off. Ben. All.							319	319			7
8	**TOTAL General Services**	246,494	139,359	103,850	489,703		489,703	(110,130)	379,573			8
	B. Health Care and Programs											
9	Medical Director			21,300	21,300		21,300		21,300			9
10	Nursing and Medical Records	557,220	31,544	2,552	591,316		591,316	23	591,339			10
10a	Therapy											10a
11	Activities	17,879	137		18,016		18,016	(7,247)	10,769			11
12	Social Services	21,084			21,084		21,084		21,084			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	596,183	31,681	23,852	651,716		651,716	(7,224)	644,492			16
	C. General Administration											
17	Administrative			143,800	143,800		143,800	(64,666)	79,134			17
18	Directors Fees											18
19	Professional Services			2,233	2,233		2,233	56,012	58,245			19
20	Dues, Fees, Subscriptions & Promotions			4,376	4,376		4,376	(288)	4,088			20
21	Clerical & General Office Expenses	33,084	3,906	32,422	69,412		69,412	27,285	96,697			21
22	Employee Benefits & Payroll Taxes			126,199	126,199		126,199		126,199			22
23	Inservice Training & Education			20	20		20	45	65			23
24	Travel and Seminar							5	5			24
25	Other Admin. Staff Transportation			5,610	5,610		5,610	3,136	8,746			25
26	Insurance-Prop.Liab.Malpractice			24,312	24,312		24,312	512	24,824			26
27	Other (specify):* Home Off. Ben. All.							6,398	6,398			27
28	**TOTAL General Administration**	33,084	3,906	338,972	375,962		375,962	28,439	404,401			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	875,761	174,946	466,674	1,517,381		1,517,381	(88,915)	1,428,466			29

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center #0047530 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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			35,373	35,373		35,373	(12,078)	23,295			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,035	66,035		66,035	36,931	102,966			32
33	Real Estate Taxes			25,941	25,941		25,941	339	26,280			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,715	12,715		12,715	374	13,089			35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,064	140,064		140,064	25,566	165,630			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			151,727	151,727		151,727		151,727			42
43	Other (specify):* Non-allowable Costs	2,153	147	28,456	30,756		30,756	(30,756)				43
44	**TOTAL Special Cost Centers**	2,153	147	180,183	182,483		182,483	(30,756)	151,727			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	877,914	175,093	786,921	1,839,928		1,839,928	(94,105)	1,745,823			45

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,842)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,003)	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	(13,347)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(238)	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	(8,362)	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	(12,791)	43		24
25	Fund Raising, Advertising and Promotional	(3,805)	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	(120,583)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (167,971)		$	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)	73,866	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 73,866		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (94,105)		37

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

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

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

Rock Falls Rehabilitation & Health Care Center

ID# 0047530

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed Special Events	$ (435)	43	1
2	Offset Transportation Revenue	(6,352)	11	2
3	Offset Miscellaneous Office Supplies Revenue	(566)	21	3
4	Disallow Chamber of Commerce Dues	(500)	20	4
5	Independent Living depreciation offset	(1,090)	30	5
6	Independent Living - Dietary	(27,522)	1	6
7	Independent Living - Food	(21,519)	2	7
8	Independent Living - Housekeeping	(18,951)	3	8
9	Independent Living - Laundry	(9,725)	4	9
10	Independent Living - Utilities	(19,007)	5	10
11	Independent Living - Maintenance	(13,899)	6	11
12	Offset Miscellaneous Salaries Activity Director	(794)	11	12
13	Offset Miscellaneous Activity Supplies	(101)	11	13
14	Disallowed Resident Flowers	(122)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(120,583)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center **#** 0047530 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(27,522)	2,396	0	0	0	0	0	0	0	0	0	(25,126)	1
2	Food Purchase	(25,361)	81	0	0	0	0	0	0	0	0	0	(25,280)	2
3	Housekeeping	(18,951)	18	0	0	0	0	0	0	0	0	0	(18,933)	3
4	Laundry	(9,725)	3	0	0	0	0	0	0	0	0	0	(9,722)	4
5	Heat and Other Utilities	(19,007)	189	0	0	0	0	0	0	0	0	0	(18,818)	5
6	Maintenance	(13,899)	1,329	0	0	0	0	0	0	0	0	0	(12,570)	6
7	Other (specify):*	0	319	0	0	0	0	0	0	0	0	0	319	7
8	**TOTAL General Services**	(114,465)	4,335	0	0	0	0	0	0	0	0	0	(110,130)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	23	0	0	0	0	0	0	0	0	0	23	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,247)	0	0	0	0	0	0	0	0	0	0	(7,247)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,247)	23	0	0	0	0	0	0	0	0	0	(7,224)	16
	C. General Administration													
17	Administrative	0	(64,666)	0	0	0	0	0	0	0	0	0	(64,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,942	0	43,070	0	0	0	0	0	0	0	56,012	19
20	Fees, Subscriptions & Promotions	(500)	0	184	28	0	0	0	0	0	0	0	(288)	20
21	Clerical & General Office Expenses	(566)	0	27,120	731	0	0	0	0	0	0	0	27,285	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	45	0	0	0	0	0	0	0	0	45	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	3,108	28	0	0	0	0	0	0	0	3,136	25
26	Insurance-Prop.Liab.Malpractice	0	0	512	0	0	0	0	0	0	0	0	512	26
27	Other (specify):*	0	0	6,398	0	0	0	0	0	0	0	0	6,398	27
28	**TOTAL General Administration**	(1,066)	(51,724)	37,372	43,857	0	0	0	0	0	0	0	28,439	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,778)	(47,366)	37,372	43,857	0	0	0	0	0	0	0	(88,915)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center **#** 0047530 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(14,437)	0	2,302	57	0	0	0	0	0	0	0	(12,078)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,577	32,354	0	0	0	0	0	0	0	36,931	32
33	Real Estate Taxes	0	0	339	0	0	0	0	0	0	0	0	339	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	337	37	0	0	0	0	0	0	0	374	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(14,437)	0	7,555	32,448	0	0	0	0	0	0	0	25,566	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(30,756)	0	0	0	0	0	0	0	0	0	0	(30,756)	43
44	**TOTAL Special Cost Centers**	(30,756)	0	0	0	0	0	0	0	0	0	0	(30,756)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(167,971)	(47,366)	44,927	76,305	0	0	0	0	0	0	0	(94,105)	45

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 2,396	$ 2,396	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	81	81	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	189	189	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,329	1,329	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	319	319	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	23	23	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	143,800	Petersen Health Care, Inc.	100.00%	79,134	(64,666)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	12,942	12,942	12
13	V								13
14	Total			$ 143,800			$ 96,434	$ * (47,366)	14

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 184	$ 184	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	27,120	27,120	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	45	45	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	5	5	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,108	3,108	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	512	512	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,398	6,398	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,302	2,302	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,577	4,577	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	339	339	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%	337	337	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			$			$ 44,927	$ * 44,927	39

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health 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%	43,070	43,070	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	28	28	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	731	731	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%	28	28	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%	57	57	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	32,354	32,354	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%	37	37	38
39	Total			$			$ 76,305	$ * 76,305	39

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Syster	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 Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	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 Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Ce # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1											1
2											2
3											3
4	N/A										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 Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	$ 285,707	$ 284,214	13,161	$ 2,396	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	13,161	81	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	13,161	18	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	13,161	3	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	13,161	189	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	13,161	1,329	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	13,161	319	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	13,161	23	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	13,161	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	13,161	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	13,161	79,134	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	13,161	12,942	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	13,161	184	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	13,161	27,120	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	13,161	45	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	13,161	5	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	13,161	3,108	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	13,161	512	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	13,161	6,398	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	13,161	2,302	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	13,161	4,577	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	13,161	339	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	13,161	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	13,161	337	24
25	TOTALS					$ 11,774,077	$ 7,528,087		$ 141,361	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Petersen Health 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	404,785	21	$	$	13,161	$	1
2	2	Food	Resident Days	404,785	21			13,161		2
3	3	Housekeeping	Resident Days	404,785	21			13,161		3
4	4	Laundry	Resident Days	404,785	21			13,161		4
5	5	Utilities	Resident Days	404,785	21			13,161		5
6	6	Maintenance	Resident Days	404,785	21			13,161		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21			13,161		7
8	10	Nursing and Medical Records	Resident Days	404,785	21			13,161		8
9	12	Social Services	Resident Days	404,785	21			13,161		9
10	17	Administrative	Resident Days	404,785	21			13,161		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676		13,161	43,070	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876		13,161	28	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478		13,161	731	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21			13,161		14
15	23	Inservice Training & Education	Resident Days	404,785	21			13,161		15
16	24	Travel and Seminar	Resident Days	404,785	21			13,161		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849		13,161	28	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21			13,161		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21			13,161		19
20	30	Depreciation	Resident Days	404,785	21	1,761		13,161	57	20
21	32	Interest	Resident Days	404,785	21	995,096		13,161	32,354	21
22	33	Real Estate Taxes	Resident Days	404,785	21			13,161		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21			13,161		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130		13,161	37	24
25	TOTALS					$ 2,346,866	$		$ 76,305	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	Bank of America		X	Mortgage	Varies	1/19/07	$ 850,000	$ 795,232	12/31/13	Varies	$ 66,035	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 850,000	$ 795,232			$ 66,035	9
	B. Non-Facility Related*											
10												10
11												11
12								Home Office Allocation-PHC			4,577	12
13								Home Office Allocation-PHO			32,354	13
14	TOTAL Non-Facility Related						$	$			$ 36,931	14
15	TOTALS (line 9+line14)						$ 850,000	$ 795,232			$ 102,966	15

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

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 27,060	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.)	2011	$ 26,109	2
3. Under or (over) accrual (line 2 minus line 1).		$ (951)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,892	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ 339	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 26,280	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	24,949	8
	2008	25,233	9
	2009	25,560	10
	2010	26,215	11
	2011	26,109	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Falls Rehabilitation & Health Care Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0047530

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-427-006	Long-Term Care Facility	$ 26,108.98	$ 26,108.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,108.98	$ 26,108.98

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,658 B. General Construction Type: Exterior Masonry Frame Masonry Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	49,223	2005	$ 21,375	1
2					2
3	TOTALS	49,223		$ 21,375	3

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	57		2005	1972	$ 273,764	$	25	$ 10,951	$ 10,951	$ 71,180	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land			2005	12,000		15	800	800	6,000	9
10	Sidewalks			2006	10,700		15	713	713	4,635	10
11	Sprinkler			2006	1,071		25	43	43	279	11
12	Tile Floor			2006	1,916		20	96	96	624	12
13	Gutters			2007	3,166		20	158	158	869	13
14	Lighting			2007	1,352		15	90	90	495	14
15	Sprinkler Head Installation			2009	6,913		15	460	460	1,610	15
16	Water Heater			2009	3,537		5	707	707	2,298	16
17	Water Line Repair			2010	7,599		7	1,086	1,086	2,715	17
18	Sidewalks			2011	3,825		15	256	256	384	18
19	Copper Line Installation			2012	4,959		7	354	354	354	19
20	Generator			2012	62,040		15	2,068	2,068	2,068	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,768			(1,768)		30
31	Building Booked					15,041			(15,041)		31
32	Building Improvement Booked					7,054			(7,054)		32
33											33
34	2012-Home Office Allocation-Land Improvements				575			37	37		34
35	2012-Home Office Allocation-Building Improvements				6,155			# 148	148		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 Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 399,572	$ 23,863		$ 17,967	$ (5,896)	$ 93,511	70

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 29,076	$ 11,510	$ 3,154	$ (8,356)	5-10 yrs.	$ 18,167	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	80,960					80,960	73
74	Home Office Allocation			2,174	2,174			74
75	TOTALS	$ 110,036	$ 11,510	$ 5,328	$ (6,182)		$ 99,127	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 530,983	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,373	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,295	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,078)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 192,638	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living (2005)	$ 100,861	$ 4,049	$ 30,369	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 100,861	$ 4,049	$ 30,369	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 6,151 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	261
Dishwasher		732
Laundry Equipment		-
Copier		4,784
Home Office Allocation		374
		6,151

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

This report must be completed even if f (977,306)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 700	$ 700	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	663,154	663,154	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,290	24,290	6
7	Other Prepaid Expenses	7,395	7,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	4,060	4,060	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 699,599	$ 699,599	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	47,900	21,375	13
14	Buildings, at Historical Cost	374,625	279,919	14
15	Leasehold Improvements, at Historical Cost	92,553	119,653	15
16	Equipment, at Historical Cost	110,035	110,036	16
17	Accumulated Depreciation (book methods)	(237,453)	(192,638)	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): Non-Care Asset-Ind. Lv. Bldg.		70,492	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 387,660	$ 408,837	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,087,259	$ 1,108,436	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,114,727	$ 1,114,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,015	18,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,032	13,032	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,892	26,892	32
33	Accrued Interest Payable	2,194	2,194	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	12,874	12,874	36
37	Accrued Management Fees	88,276	88,276	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,276,010	$ 1,276,010	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	795,232	795,232	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	14,500	14,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 809,732	$ 809,732	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,085,742	$ 2,085,742	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (998,483)	$ (977,306)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,087,259	$ 1,108,436	48

***(See instructions.)**

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,111,913)	1	
2	Restatements (describe):		2	
3	**Rounding**		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,111,913)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	113,430	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)**	$ 113,430	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)**	$ (998,483)	24	*

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,791,176	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,791,176	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,842	14
15	Telephone, Television and Radio	1,905	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Transportation Revenue	7,813	28
28a	Private Revenue - Arrowwood (Expense Offset)	148,622	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 156,435	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,953,358	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	489,703	31
32	Health Care	651,716	32
33	General Administration	375,962	33
	B. Capital Expense		
34	Ownership	140,064	34
	C. Ancillary Expense		
35	Special Cost Centers	30,756	35
36	Provider Participation Fee	151,727	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,839,928	40
41	**Income before Income Taxes (line 30 minus line 40)****	113,430	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 113,430	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,564,941	44
45	Private Pay - Net Inpatient Revenue	226,235	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,791,176	49

* **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.**

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 65,840	$ 31.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,091	3,276	96,854	29.56	3
4	Licensed Practical Nurses	6,385	6,596	131,521	19.94	4
5	CNAs & Orderlies	23,897	24,699	240,053	9.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,299	1,445	15,093	10.44	9
10	Activity Assistants					10
11	Social Service Workers	1,492	1,603	21,084	13.15	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,121	14.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,364	9,758	83,521	8.56	15
16	Dishwashers					16
17	Maintenance Workers	2,466	2,466	36,368	14.75	17
18	Housekeepers	6,330	7,288	68,878	9.45	18
19	Laundry	3,220	3,340	28,606	8.56	19
20	Administrator	2,080	2,080	79,134	38.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,247	2,247	33,084	14.72	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	1,397	1,462	27,891	19.08	33
34	TOTAL (lines 1 - 33)	67,428	70,420	$ 957,048 *	$ 13.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	21,300	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,552	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)		$ 23,852		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	974	1,039	22,952	22.09
Transportation	274	274	2,786	10.17
Marketing	149	149	2,153	14.45
TOTAL	1,397	1,462	27,891	

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathryn Langan	Administrator	0	$ 79,134
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,134

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 143,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 143,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 740
Comcast Cable	Computer Services	1,493
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,233

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,844
Unemployment Compensation Insurance	24,617
FICA Taxes	69,068
Employee Health Insurance	2,220
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	450
TOTAL (agree to Schedule V, line 22, col.8)	$ 126,199

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	464
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 94	944
Miscellaneous Licenses & Permits	478
Miscellaneous Dues & Subscriptions	500
Home Office Allocation	212
Less: Public Relations Expense	(500)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,088

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	5
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5

**See instructions.

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,233
Home Office Allocation		
Sorling Northrup	Legal	1,079
Ginoli & Company	Accountants	435
Miscellaneous	Computer Services	38
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2000
Access 2 Go	Computer Services	84
Stratus Networks	Computer Services	83
Kemper Technology	Computer Services	136
CCH	Computer Services	7
Medifax	Computer Services	16
Vision Share/Ability Network	Computer Services	152
Barracuda	Computer Services	5
CIAN	Computer Services	41
Comcast	Computer Services	13
Postini	Computer Services	129
Optimizer Systems	Other Prof Fees	20
Marotta Gund Budd & Dzera	Other Prof Fees	51292
David Budde	Other Prof Fees	8
Courtney Bourban	Other Prof Fees	114
All Scripts	Other Prof Fees	349
Heritage Enterprises	Other Prof Fees	8
Miscellaneous Vendors	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		58,245

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

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,965** 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. $ **151,727**
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? **Yes** 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. $ **3,842**

(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. $ **6,352**
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? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $

(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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning **1/1/2012**
Period End **12/31/2012**

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**	**Beds**	**%**
Independent Living	3,841	22.59%	21	26.92%
Nursing Home	13,161	77.41%	57	73.08%
	17,002	100.00%	78	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	121,833	22.59%	27,522	Census	1
Food	95,260	22.59%	21,519	Census	2
Housekeeping	83,892	22.59%	18,951	Census	3
Laundry	43,050	22.59%	9,725	Census	4
Utilities	84,140	22.59%	19,007	Census	5
Maintenance	61,528	22.59%	13,899	Census	6
Depreciation (Building)	4,049	26.92%	1,090	Beds	30
Total	493,752		111,713		

Building Cost Offset:

P12 Building Cost		26.92%	(7)	Beds

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
Independent Living overhead and depreciation costs have been offset on P5A.

RECONCILIATION REPORT **Template** **09:16 AM** **6/14/2013**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-94,105	equal to	-94,105	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	102,966	equal to	102,966	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	26,280	equal to	26,280	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	23,295	equal to	23,295	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,089	equal to	13,089	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	489,703	equal to	489,703	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	651,716	equal to	651,716	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	375,962	equal to	375,962	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	140,064	equal to	140,064	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	30,756	equal to	30,756	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	151,727	equal to	151,727	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	557,220	equal to	557,220	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	17,879	equal to	17,879	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	21,084	equal to	21,084	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	112,642	equal to	112,642	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,368	equal to	36,368	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	68,878	equal to	68,878	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	28,606	equal to	28,606	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	79,134	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	33,084	equal to	33,084	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	957,048	equal to	877,914	79,134	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	21,300	< or = to	21,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,552	< or = to	2,552	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	79,134	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	143,800	equal to	143,800	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	2,233	equal to	2,233	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	126,199	equal to	126,199	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,088	equal to	4,088	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5	equal to	5	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	151,727	equal to	151,727	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	73,866	equal to	73,866	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	795,232	equal to	795,232	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	26,892	equal to	26,892	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	21,375	equal to	21,375	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	399,572	equal to	399,572	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	110,036	equal to	110,036	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	192,638	equal to	192,638	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-998,483	equal to	-998,483	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	113,430	equal to	113,430	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..9	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,087,259	equal to	1,087,259	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	112,642	9,191	0	121,833	0	121,833	-25,126	96,707
2. Food Purchase	0	95,260	0	95,260	0	95,260	-25,280	69,980
3. Housekeeping	68,878	15,014	0	83,892	0	83,892	-18,933	64,959
4. Laundry	28,606	14,444	0	43,050	0	43,050	-9,722	33,328
5. Heat and Other Utilities	0	0	84,140	84,140	0	84,140	-18,818	65,322
6. Maintenance	36,368	5,450	19,710	61,528	0	61,528	-12,570	48,958
7. Other (specify)*	0	0	0	0	0	0	319	319
8. Total General Services	246,494	139,359	103,850	489,703	0	489,703	-110,130	379,573
9. Medical Director	0	0	21,300	21,300	0	21,300	0	21,300
10. Nursing & Medical Records	557,220	31,544	2,552	591,316	0	591,316	23	591,339
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	17,879	137	0	18,016	0	18,016	-7,247	10,769
12. Social Services	21,084	0	0	21,084	0	21,084	0	21,084
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	596,183	31,681	23,852	651,716	0	651,716	-7,224	644,492
17. Administrative	0	0	143,800	143,800	0	143,800	-64,666	79,134
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,233	2,233	0	2,233	56,012	58,245
20. Fees, Subscriptions & Promotion	0	0	4,376	4,376	0	4,376	-288	4,088
21. Clerical & General Office	33,084	3,906	32,422	69,412	0	69,412	27,285	96,697
22. Employee Benefits & Payroll	0	0	126,199	126,199	0	126,199	0	126,199
23. Inservice Training & Education	0	0	20	20	0	20	45	65
24. Travel and Seminar	0	0	0	0	0	0	5	5
25. Other Admin. Staff Trans	0	0	5,610	5,610	0	5,610	3,136	8,746
26. Insurance-Prop.Liab.Malpractice	0	0	24,312	24,312	0	24,312	512	24,824
27. Other (specify)*	0	0	0	0	0	0	6,398	6,398
28. Total General Adminis	33,084	3,906	338,972	375,962	0	375,962	28,439	404,401
29. Total General Administrative	875,761	174,946	466,674	1,517,381	0	1,517,381	-88,915	1,428,466
30. Depreciation	0	0	35,373	35,373	0	35,373	-12,078	23,295
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	66,035	66,035	0	66,035	36,931	102,966
33. Real Estate	0	0	25,941	25,941	0	25,941	339	26,280

34.	Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35.	Rent - Equipment & Vehicles		0	0	12,715	12,715	0	12,715	374	13,089
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	140,064	140,064	0	140,064	25,566	165,630
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	0	0	0	0	0	0	0
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	151,727	151,727	0	151,727	0	151,727
43.	Other (specify):*		2,153	147	28,456	30,756	0	30,756	-30,756	0
44.	Total Special Cost Ce		2,153	147	180,183	182,483	0	182,483	-30,756	151,727
45.	Grand Total		877,914	175,093	786,921	1,839,928	0	1,839,928	-94,105	1,745,823

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	700	700
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	663,154	663,154
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	24,290	24,290
7. Other Prepaid Expenses	7,395	7,395
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	4,060	4,060
10. Total current assets	699,599	699,599
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	47,900	21,375
14. Buildings, at Historical Cost	374,625	279,919
15. Leasehold Improvements, Historical Cost	92,553	119,653
16. Equipment, at Historical Cost	110,035	110,036
17. Accumulated Depreciation (book methods)	-237,453	-192,638
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	70,492
24. Total Long-Term Assets	387,660	408,837
25. Total Assets	1,087,259	1,108,436
CURRENT LIABILITIES		
26. Accounts Payable	1,114,727	1,114,727
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	18,015	18,015
31. Accrued Taxes Payable	13,032	13,032
32. Accrued Real Estate Taxes	26,892	26,892
33. Accrued Interest Payable	2,194	2,194
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	12,874	12,874

37. Other Current Liabilities (specify):	88,276	88,276
38. Total Current Liabilities	1,276,010	1,276,010
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	795,232	795,232
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	14,500	14,500
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	809,732	809,732
46.Total Liabilities	2,085,742	2,085,742
47.Total Equity	-998,483	-977,306
48.Total Liabilities and Equity	1,087,259	1,108,436

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,791,176
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,791,176
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,842
15. Telephone, Television, and Radio	1,905
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	5,747
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	156,435
Subtotal - Other Revenue	156,435
30. Total Revenue	1,953,358
31. General Services	469,748
32. Health Care	577,808
33. General Administration	357,510
34. Ownership	122,071

35.	Special Cost Centers	29,673
35.	Provider Participation Fee	31,208
37.	Other	0
40.	Total Expenses	1,588,018
41.	Income Before Income Taxes	365,340
42.	Income Taxes	0
43.	Net Income or Loss for the Year	365,340

Enter Cost Center Expenses **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 6/14/2013 09:16:26 AM

HSA Number: 1 Name: **Rock Falls Rehabilitation & Health Care Center**

Cost report period From: 1/1/2012 To: 12/31/2012 Base Number: 444

If this is an ICF/DD 16 facility, enter a 1 in cell C6 N

Licensed bed days: 20,805 Occupancy: 13,167 Pct. of occupancy: 63.29%

Illinois Public Aid Support Rate: $

Genl Services Salary/Wage:	246,494	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage:	33,084	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage:	877,914	Col 1, Line 44 ---Audit Adj:	
Employee Benefits:	126,199	Col 8, Line 22 ---Audit Adj:	
Total General Services:	379,573	Col 8, Line 8 ---Audit Adj:	
Total General Admin:	404,401	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month =	13	divided by 2 =
Beginning Day + Ending Day =	32	divided by 60.8 =
Beginning Year + Ending Year =	224	multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

$246,494
$877,914
28.0772%
$126,199

$35,433
$379,573
$415,006

$33,084
$877,914
3.7685%

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

	$126,199
	$4,756
	$404,401
	$126,199
	$282,958
	6.5
	0.526315789
	1344
	1351.026316
	907.00
	444
	1
	1
	$415,006
	1
	$415,006

$282,958	
1	
	$282,958
	$697,964
$45.83	
$697,964	
13,167	
$53.01	
20,805	
0.93	
19,349	
13,167	
6,182	
2,061	
13,167	
15,228	

$697,964
15228

$45.83

$48.45
$45.83

$2.62

0.5

$1.31

$45.83

47.14

$48.45
$45.83

$2.62

0.5

$1.31

4.345

$1.310

$45.83

$47.14

$47.14

$48.45
$39.86

F/DD 16 Facilities)
rcentiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655