		FOR BHF USE					

LL1

DEPARTMI
FINANCIA

I. **IDPH License ID Number:** 0047530

Facility Name: Rock Falls Rehab & HCC

Address: 430 Martin Road (Number) Rock Falls (City)

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		GOV
	Charitable Corp.		Individual		
	Trust		Partnership		
IRS Exemption Code			Corporation		
			"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:

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE C
THAT IS NECESSARY TO ACCOMPLISH THE ST
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. I
OF THIS INFORMATION IS MANDATORY. FAII
ANY INFORMATION ON OR BEFORE THE DUE
RESULT IN CESSATION OF PROGRAM PAYME
HAS BEEN APPROVED BY THE FORMS MANA

2013
STATE OF ILLINOIS
ENT OF HEALTHCARE AND FAMILY SERVICES
L AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

61071
Zip Code

ERNMENTAL
State
County
Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to t
State of Illinois, for the period from 1/1/2013 to
and certify to the best of my knowledge and belief that the said c
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than prov
is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informati
in this cost report may be punishable by fine and/or imprisonme

Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) Mark B. Petersen (Title) Chief Executive Officer
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

)F INFORMATIOI
ſATUTORY
DISCLOSURE
LURE TO PROVIDI
DATE WILI
NTS. THIS FORM
GEMENT CENTER.

the
12/31/2013
contents

/ider)
e.

on
ent.

(Date)

(Date)

ſ ( )

Y SERVICES

e # (217) 782-1630

Facility Name & ID Number Rock Falls Rehab & HCC

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	27	Skilled (SNF)	27	9,855
2		Skilled Pediatric (SNF/PED)		
3	30	Intermediate (ICF)	30	10,950
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	57	TOTALS	57	20,805

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			582	582
9	SNF/PED				
10	ICF	9,890	2,268		12,158
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	9,890	2,268	582	12,740

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.24%

0047530 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 582

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 **Fiscal Year:** 12/31/2013

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

Facility Name & ID Number Rock Falls Rehab & HCC #

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

	Operating Expenses	Costs Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	A. General Services	1	2	3	4
1	Dietary	118,049	7,066	1,368	126,483
2	Food Purchase		106,764		106,764
3	Housekeeping	87,955	16,864		104,819
4	Laundry	17,621	14,332		31,953
5	Heat and Other Utilities			90,241	90,241
6	Maintenance	34,142	6,671	24,851	65,664
7	Other (specify):* Home Off. Ben. All.				
8	**TOTAL General Services**	257,767	151,697	116,460	525,924
	B. Health Care and Programs				
9	Medical Director			16,800	16,800
10	Nursing and Medical Records	590,813	59,567	3,866	654,246
10a	Therapy			42,247	42,247
11	Activities	17,432	421	2,897	20,750
12	Social Services	18,625			18,625
13	CNA Training				
14	Program Transportation				
15	Other (specify):* Home Off. Ben. All.				
16	**TOTAL Health Care and Programs**	626,870	59,988	65,810	752,668
	C. General Administration				
17	Administrative			209,800	209,800
18	Directors Fees				
19	Professional Services			9,635	9,635
20	Dues, Fees, Subscriptions & Promotions			4,032	4,032
21	Clerical & General Office Expenses	23,098	3,709	43,265	70,072
22	Employee Benefits & Payroll Taxes			158,817	158,817
23	Inservice Training & Education			25	25
24	Travel and Seminar				
25	Other Admin. Staff Transportation			9,776	9,776
26	Insurance-Prop.Liab.Malpractice			23,317	23,317
27	Other (specify):* Home Off. Ben. All.				
28	**TOTAL General Administration**	23,098	3,709	458,667	485,474
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	907,735	215,394	640,937	1,764,066

***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 includ

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	126,483	(24,747)	101,736			1
	106,764	(25,912)	80,852			2
	104,819	(22,563)	82,256			3
	31,953	(6,886)	25,067			4
	90,241	(20,961)	69,280			5
	65,664	(12,921)	52,743			6
		142	142			7
	525,924	(113,848)	412,076			8
	16,800		16,800			9
	654,246	(793)	653,453			10
	42,247		42,247			10a
	20,750	(8,285)	12,465			11
	18,625		18,625			12
						13
						14
						15
	752,668	(9,078)	743,590			16
	209,800	(130,666)	79,134			17
						18
	9,635	66,621	76,256			19
	4,032	265	4,297			20
	70,072	33,453	103,525			21
	158,817	(14)	158,803			22
	25	50	75			23
		3	3			24
	9,776	2,324	12,100			25
	23,317	449	23,766			26
		2,880	2,880			27
	485,474	(24,635)	460,839			28
	1,764,066	(147,561)	1,616,505			29

e a detailed explanation of each reclassification.

Facility Name & ID Number **Rock Falls Rehab & HCC**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	D. Ownership	1	2	3	4
30	Depreciation			26,550	26,550
31	Amortization of Pre-Op. & Org.				
32	Interest			22,896	22,896
33	Real Estate Taxes			25,356	25,356
34	Rent-Facility & Grounds				
35	Rent-Equipment & Vehicles			14,758	14,758
36	Other (specify):*				
37	**TOTAL Ownership**			89,560	89,560
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation				
39	Ancillary Service Centers		12,169		12,169
40	Barber and Beauty Shops				
41	Coffee and Gift Shops				
42	Provider Participation Fee			106,701	106,701
43	Other (specify):* **Non-allowable Costs**		584	60,579	61,163
44	**TOTAL Special Cost Centers**		12,753	167,280	180,033
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	907,735	228,147	897,777	2,033,659

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	26,550	(1,244)	25,306			30
						31
	22,896	15,441	38,337			32
	25,356	202	25,558			33
						34
	14,758	372	15,130			35
						36
	89,560	14,771	104,331			37
						38
	12,169		12,169			39
						40
						41
	106,701		106,701			42
	61,163	(61,163)				43
	180,033	(61,163)	118,870			44
	2,033,659	(193,953)	1,839,706			45

0.

Facility Name & ID Number Rock Falls Rehab & HCC **#** 0047530

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should**
In column 2 below, reference the line on which the particula

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY
1	Day Care	$		$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(2,958)	2	
5	Telephone, TV & Radio in Resident Rooms	(7,621)	43	
6	Rented Facility Space			
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	603	30	
10	Interest and Other Investment Income	(10,144)	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	(135)	43	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)			
17	Non-Care Related Fees			
18	Fines and Penalties	(15,984)	43	
19	Entertainment			
20	Contributions			
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(32,000)	43	
25	Fund Raising, Advertising and Promotional	(2,082)	43	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	CNA Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule See Page 5A	(132,163)	Various	
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (202,484)		$

BHF USE ONLY									
48		49		50		51		52	

be adjusted out of Schedule V, pages 3 or 4 via column 7.
r cost was included. (See instructions.)

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

			1	2	
			Amount	**Reference**	
31	Non-Paid Workers-Attach Schedule*		$		31
32	Donated Goods-Attach Schedule*				32
33	Amortization of Organization & Pre-Operating Expense				33
34	Adjustments for Related Organization Costs (Schedule VII)		8,531	Various	34
35	Other- Attach Schedule				35
36	**SUBTOTAL (B): (sum of lines 31-35)**		$ 8,531		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**		$ (193,953)		37

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

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

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

Rock Falls Rehab & HCC

ID# 0047530

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed Special Events	$ 622	43	1
2	Offset Transportation Revenue	(8,285)	11	2
3	Offset Miscellaneous Office Supplies Revenue	(45)	21	3
4	Disallow Chamber of Commerce Dues	(600)	20	4
5	Independent Living depreciation offset	(4,049)	30	5
6	Independent Living - Dietary	(27,257)	1	6
7	Independent Living - Food	(23,008)	2	7
8	Independent Living - Housekeeping	(22,588)	3	8
9	Independent Living - Laundry	(6,886)	4	9
10	Independent Living - Utilities	(19,447)	5	10
11	Independent Living - Maintenance	(14,151)	6	11
12	Labs-Part A	(1,309)	43	12
13	Disallowed Air Travel Expense	(959)	11	13
14	To offset NICOR gas refund check	(1,704)	5	14
15	Offset Miscellaneous Nursing Supplies Revenue	(802)	10	15
16	Offset Cable TV Revenue	(1,695)	43	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**	(132,163)		49

Facility Name & ID Number **Rock Falls Rehab & HCC**

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE
	A. General Services	**5 & 5A**	**6**	**6A**	**6B**
1	Dietary	**(27,257)**	**2,510**	**0**	**0**
2	Food Purchase	**(23,008)**	**54**	**0**	**0**
3	Housekeeping	**(22,588)**	**25**	**0**	**0**
4	Laundry	**(6,886)**	**0**	**0**	**0**
5	Heat and Other Utilities	**(21,151)**	**190**	**0**	**0**
6	Maintenance	**(14,151)**	**1,230**	**0**	**0**
7	Other (specify):*	**0**	**142**	**0**	**0**
8	**TOTAL General Services**	**(115,041)**	**4,151**	**0**	**0**
	B. Health Care and Programs				
9	Medical Director	**0**	**0**	**0**	**0**
10	Nursing and Medical Records	**(802)**	**9**	**0**	**0**
10a	Therapy	**0**	**0**	**0**	**0**
11	Activities	**(9,244)**	**0**	**0**	**0**
12	Social Services	**0**	**0**	**0**	**0**
13	CNA Training	**0**	**0**	**0**	**0**
14	Program Transportation	**0**	**0**	**0**	**0**
15	Other (specify):*	**0**	**0**	**0**	**0**
16	**TOTAL Health Care and Programs**	**(10,046)**	**9**	**0**	**0**
	C. General Administration				
17	Administrative	**0**	**(130,666)**	**0**	**0**
18	Directors Fees	**0**	**0**	**0**	**0**
19	Professional Services	**0**	**5,293**	**0**	**61,328**
20	Fees, Subscriptions & Promotions	**(600)**	**0**	**336**	**529**
21	Clerical & General Office Expenses	**(45)**	**0**	**31,112**	**2,386**
22	Employee Benefits & Payroll Taxes	**0**	**0**	**0**	**(14)**
23	Inservice Training & Education	**0**	**0**	**50**	**0**
24	Travel and Seminar	**0**	**0**	**3**	**0**
25	Other Admin. Staff Transportation	**0**	**0**	**2,324**	**0**
26	Insurance-Prop.Liab.Malpractice	**0**	**0**	**449**	**0**
27	Other (specify):*	**0**	**0**	**2,880**	**0**
28	**TOTAL General Administration**	**(645)**	**(125,373)**	**37,154**	**64,229**
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	**(125,732)**	**(121,213)**	**37,154**	**64,229**

STATE OF ILLINOIS

\# 0047530 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary A
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
(24,747)	1
(22,954)	2
(22,563)	3
(6,886)	4
(20,961)	5
(12,921)	6
142	7
(110,890)	8
0	9
(793)	10
0	10a
(9,244)	11
0	12
0	13
0	14
0	15
(10,037)	16
(130,666)	17
0	18
66,621	19
265	20
33,453	21
(14)	22
50	23
3	24
2,324	25
449	26
2,880	27
(24,635)	28
(145,562)	29

STATE OF ILLINOIS

Facility Name & ID Number **Rock Falls Rehab & HCC**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**
30	Depreciation	**(11,670)**	**0**	**2,062**	**140**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**
32	Interest	**0**	**0**	**3,431**	**22,154**
33	Real Estate Taxes	**0**	**0**	**202**	**0**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**
35	Rent-Equipment & Vehicles	**0**	**0**	**372**	**0**
36	Other (specify):*	**0**	**0**	**0**	**0**
37	**TOTAL Ownership**	**(11,670)**	**0**	**6,067**	**22,294**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**
42	Provider Participation Fee	**0**	**0**	**0**	**0**
43	Other (specify):*	**(1,779)**	**0**	**0**	**0**
44	**TOTAL Special Cost Centers**	**(1,779)**	**0**	**0**	**0**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(139,181)**	**(121,213)**	**43,221**	**86,523**

 # 0047530 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary B
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
(9,468)	30
0	31
25,585	32
202	33
0	34
372	35
0	36
16,691	37
0	38
0	39
0	40
0	41
0	42
(1,779)	43
(1,779)	44
(130,650)	45

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defin

1 OWNERS		2 RELATED NURSI
Name	**Ownership %**	**Name**
Mark B. Petersen	100	See PG6 - Supp

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in 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 Or Name of Related O
1	V		1	Dietary	$	Petersen Health Ca
2	V		2	Food		Petersen Health Ca
3	V		3	Housekeeping		Petersen Health Ca
4	V		4	Laundry		Petersen Health Ca
5	V		5	Utilities		Petersen Health Ca
6	V		6	Maintenance		Petersen Health Ca
7	V		7	Mgmt. Allocation of Benefits		Petersen Health Ca
8	V		10	Nursing and Medical Records		Petersen Health Ca
9	V		10A	Therapy		Petersen Health Ca
10	V		15	Mgmt. Allocation of Benefits		Petersen Health Ca
11	V		17	Administrative	209,800	Petersen Health Ca
12	V		19	Professional Services		Petersen Health Ca
13	V					
14	Total				$ 209,800	

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

ed in the instructions. Use Page 6-Supplemental as necessary.

NG HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Busine
		See PG6 - Supp		

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
ıre, Inc.	100.00%	$ 2,510	$ 2,510
ıre, Inc.	100.00%	54	54
ıre, Inc.	100.00%	25	25
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	190	190
ıre, Inc.	100.00%	1,230	1,230
ıre, Inc.	100.00%	142	142
ıre, Inc.	100.00%	9	9
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	79,134	(130,666)
ıre, Inc.	100.00%	5,293	5,293
		$ 88,587	$ * (121,213)

ess

1
2
3
4
5
6
7
8
9
10
11
12
13
14

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Or
	Schedule V	Line	Item	Amount	Name of Related O
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care
16	V	21	Clerical and General Office		Petersen Health Care
17	V	23	Inservice Training & Education		Petersen Health Care
18	V	24	Travel and Seminar		Petersen Health Care
19	V	25	Other Admin. Staff Transport.		Petersen Health Care
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care
22	V	30	Depreciation		Petersen Health Care
23	V	32	Interest		Petersen Health Care
24	V	33	Real Estate Taxes		Petersen Health Care
25	V	34	Rent-Facility and Grounds		Petersen Health Care
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				
39	Total			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
, Inc.	100.00%	$ 336	$ 336
, Inc.	100.00%	31,112	31,112
, Inc.	100.00%	50	50
, Inc.	100.00%	3	3
, Inc.	100.00%	2,324	2,324
, Inc.	100.00%	449	449
, Inc.	100.00%	2,880	2,880
, Inc.	100.00%	2,062	2,062
, Inc.	100.00%	3,431	3,431
, Inc.	100.00%	202	202
, Inc.	100.00%	0	
, Inc.	100.00%	372	372
		$ 43,221	$ * 43,221

15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Or
Schedule V		Line	Item	Amount	Name of Related O
15	V	1	Dietary	$	Petersen Health Oper
16	V	2	Food		Petersen Health Oper
17	V	3	Housekeeping		Petersen Health Oper
18	V	4	Laundry		Petersen Health Oper
19	V	5	Utilities		Petersen Health Oper
20	V	6	Maintenance		Petersen Health Oper
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Oper
22	V	10	Nursing and Medical Records		Petersen Health Oper
23	V	12	Social Services		Petersen Health Oper
24	V	17	Administrative		Petersen Health Oper
25	V	19	Professional Services		Petersen Health Oper
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Oper
27	V	21	Clerical and General Office		Petersen Health Oper
28	V	22	Employee Benefits & Payroll		Petersen Health Oper
29	V	23	Inservice Training & Education		Petersen Health Oper
30	V	24	Travel and Seminar		Petersen Health Oper
31	V	25	Other Admin. Staff Transport.		Petersen Health Oper
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Oper
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Oper
34	V	30	Depreciation		Petersen Health Oper
35	V	32	Interest		Petersen Health Oper
36	V	33	Real Estate Taxes		Petersen Health Oper
37	V	34	Rent-Facility and Grounds		Petersen Health Oper
38	V	35	Rent-Equipment & Vehicles		Petersen Health Oper
39	Total			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
rations, LLC	100.00%	$ 0	$
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	61,328	61,328
rations, LLC	100.00%	529	529
rations, LLC	100.00%	2,386	2,386
rations, LLC	100.00%	(14)	(14)
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	140	140
rations, LLC	100.00%	22,154	22,154
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
		$ 86,523	$ * 86,523

15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	Ownership %	Name
1			Aledo Health Care Center
2			Arcola Health Care Center
3			Aspen Rehab & Health Care
4			Batavia Rehab & Health Care Cent
5			Bement Health Care Center
6			Benton Rehab & Health Care Cent
7			Bloomington Rehab & Health Care
8			Casey Health Care Center
9			Charleston Rehab & Health Care C
10			Cisne Rehab & Health Care Center
11			Countryview Care Center of Macor
12			Countryview Terrace
13			Cumberland Rehab & Health Care
14			Decatur Rehab & Health Care Cen
15			Eastside Health & Rehabilitation C
16			Eastview Terrace
17			El Paso Health Care Center
18			Enfield Rehab & Health Care Cent
19			Farmer City Rehab & Health Care
20			Flanagan Rehab & Health Care Ce
21			Flora Gardens Care Center
22			Flora Health Care Center
23			Fondulac Rehab & Health Care Ce
24			Havana Health Care Center
25			Illini Heritage Rehab & Health Car
26			Jonesboro Rehab & Health Care C
27			Kewanee Care Home
28			LaHarpe Davier Health Care Cente
29			Lebanon Care Center
30			Marigold Rehab & Health Care Ce

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping
	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping
ter	Batavia	Petersen Health Enterp	Peoria	Mgmt/Bookkeeping
	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping
er	Benton	Petersen Health Systen	Peoria	Mgmt/Bookkeeping
Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality
	Casey	Petersen Restaurants, I	Peoria	Restaurant
Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
mb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
	Louisville	Petersen Health Care V	Sullivan	Lessor
Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
ter	Decatur	Petersen Health Care X	Peoria	Lessor
enter	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor
	Sullivan	Petersen West Frankfo	West Frankfort	Lessor
	El Paso	Midwest Health Care, I	Peoria	Mgmt/Bookkeeping
er	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor
Center	Farmer City	Petersen Roseville, LL(	Roseville	Lessor
nter	Flanagan			
	Flora			
	Flora			
nter	East Peoria			
	Havana			
re	Champaign			
enter	Jonesboro			
	Kewanee			
er	LaHarpe			
	Lebanon			
nter	Galesburg			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

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

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Sullivan			
e Center	McLeansboro			
	Mt. Vernon			
nter	Newman			
nter	Nokomis			
	North Aurora			
re Center	Princeton			
	Mattoon			
	Piper City			
e Center	Morrison			
Center	Polo			
Center	Prairie City			
	Brighton			
	Rochelle			
nter	Rochelle			
enter	Rock Falls			
	Rock Falls			
Center	Roseville			
nter	Rosiclare			
	Kewanee			
enter	Sandwich			
	Sandwich			
	Harrisburg			
Center	Shelbyville			
Center	South Elgin			
	Watseka			
	Sullivan			
	Canton			
	Swansea			
er	Pekin			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Toulon Health Care Center
2			Tuscola Health Care Center
3			Twin Lakes Rehab & Health Care (
4			Vandalia Rehab & Health Care Ce
5			Watseka Health Care Center
6			Westside Rehab & Care Center
7			Whispering Oaks
8			White Oak Rehab & Health Care C
9			Willow Rose Rehab & Health Care
10			Sheldon Health Care Center
11			Tuscola Health Care Center
12			Effingham Health Care Center
13			Collinsville Health Care Center
14			Ozark Rehab & Health Care Cente
15			South Shore Health Care, LLC
16			Cedargate Skilled Nursing Facility
17			Tarkio Rehab & Health Care Cent
18			Shangri-la Rehab & Living Center
19			Prairie Rose Care Center
20			Illini Heritage Rehab & Health Cer
21			Courtyard Estates of Kewanee
22			Courtyard Estates of Bradford
23			Courtyard Estates of Galva
24			Courtyard Estates of Walcott
25			Courtyard Village of Kewanee
26			Lakewood Village
27			Courtyard Estates of Monmouth
28			Riverview Estates
29			Simple Blessings
30			Courtyard Estates of Bushnell

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Toulon			
	Tuscola			
Center	Paris			
nter	Vandalia			
	Watseka			
	West Frankfort			
	Rosiclare			
Center	Mt. Vernon			
Center	Jerseyville			
	Sheldon			
	Tuscola			
	Effingham			
	Collinsville			
r	Osage Beach, MO			
	Gary, IN			
	Poplar Bluff, MO			
er	Tarkio, MO			
	Blue Springs, MO			
	Pana			
nter	Champaign			
	Kewanee			
	Bradford			
	Galva			
	Walcott			
	Kewanee			
	Charleston			
	Monmouth			
	Havana			
	Casey			
	Bushnell			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number Rock Falls Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Courtyard Estates of Canton
2			Legacy Estates of Monmouth
3			Courtyard Estates of Sullivan
4			Courtyard Estates of Peoria
5			Cornerstone Health and Rehabilita
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Canton			
	Monmouth			
	Sullivan			
	Peoria			
tion	Peoria			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their re must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest
1				
2				
3				
4	N/A			
5				
6				
7				
8				
9				
10				
11				
12				
13				

* If the owner(s) of this facility or any other related parties listed above have receive of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE A

** This must include all forms of compensation paid by related entities and all FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES

Board of Directors.
elatives who receive any type of compensation from this home

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

ed compensation from other nursing homes, attach a schedule detailing the name(s)
AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

ocated to Schedule V of this report (i.e., management fees).
RMS OF COMPENSATION RECEIVED FROM THIS HOME,
ULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rock Falls Rehab & HCC #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	1,560,986	
2	2	Food	Resident Days	1,560,986	
3	3	Housekeeping	Resident Days	1,560,986	
4	4	Laundry	Resident Days	1,560,986	
5	5	Utilities	Resident Days	1,560,986	
6	6	Maintenance	Resident Days	1,560,986	
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
8	10	Nursing and Medical Records	Resident Days	1,560,986	
9	10A	Therapy	Resident Days	1,560,986	
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
11	17	Administrative	Resident Days	1,560,986	
12	19	Professional Services	Resident Days	1,560,986	
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	
14	21	Clerical and General Office	Resident Days	1,560,986	
15	23	Inservice Training & Education	Resident Days	1,560,986	
16	24	Travel and Seminar	Resident Days	1,560,986	
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
20	30	Depreciation	Resident Days	1,560,986	
21	32	Interest	Resident Days	1,560,986	
22	33	Real Estate Taxes	Resident Days	1,560,986	
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	
25	TOTALS				

ce

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

5 Number of ıbunits Being ocated 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
75	$ 307,592	$ 295,212	12,740	$ 2,510
75	6,577	0	12,740	54
75	3,057	0	12,740	25
75	0	0	12,740	0
75	23,338	0	12,740	190
75	150,672	97,358	12,740	1,230
75	17,394	0	12,740	142
75	1,082	0	12,740	9
75	0	0	12,740	0
75	0	0	12,740	0
75	4,578,456	4,578,456	12,740	79,134
75	648,504	0	12,740	5,293
75	41,231	0	12,740	336
75	3,812,055	3,383,297	12,740	31,112
75	6,148	0	12,740	50
75	313	0	12,740	3
75	284,745	0	12,740	2,324
75	54,993	0	12,740	449
75	352,851	0	12,740	2,880
75	252,711	0	12,740	2,062
75	420,365	0	12,740	3,431
75	24,742	0	12,740	202
75	0	0	12,740	0
75	45,546	0	12,740	372
	$ 11,032,372	$ 8,354,323		$ 131,808

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Facility Name & ID Number Rock Falls Rehab & HCC #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	408,598	
2	2	Food	Resident Days	408,598	
3	3	Housekeeping	Resident Days	408,598	
4	4	Laundry	Resident Days	408,598	
5	5	Utilities	Resident Days	408,598	
6	6	Maintenance	Resident Days	408,598	
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	
8	10	Nursing and Medical Records	Resident Days	408,598	
9	12	Social Services	Resident Days	408,598	
10	17	Administrative	Resident Days	408,598	
11	19	Professional Services	Resident Days	408,598	
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	
13	21	Clerical and General Office	Resident Days	408,598	
14	22	Employee Benefits & Payroll	Resident Days	408,598	
15	23	Inservice Training & Education	Resident Days	408,598	
16	24	Travel and Seminar	Resident Days	408,598	
17	25	Other Admin. Staff Transport.	Resident Days	408,598	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	
20	30	Depreciation	Resident Days	408,598	
21	32	Interest	Resident Days	408,598	
22	33	Real Estate Taxes	Resident Days	408,598	
23	34	Rent-Facility and Grounds	Resident Days	408,598	
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	
25	TOTALS				

0047530 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

ce

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

5 Number of ıbunits Being ocated 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
21	$	$	12,740	$
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21	1,966,927		12,740	61,328
21	16,972		12,740	529
21	76,520		12,740	2,386
21	(465)		12,740	(14)
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21			12,740	
21	4,500		12,740	140
21	710,525		12,740	22,154
21			12,740	
21			12,740	
21			12,740	
	$ 2,774,979	$		$ 86,523

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Facility Name & ID Number Rock Falls Rehab & HCC #

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required
	A. Directly Facility Related				
	Long-Term				
1	Bank of America		X	Mortgage	Varies
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	TOTAL Facility Related				
	B. Non-Facility Related*				
10					
11					
12					
13					
14	TOTAL Non-Facility Related				
15	TOTALS (line 9+line14)				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

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

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

necessary.)

5	6		7	8	9	10	
Date of Note	Amount of Note			Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	Original		Balance				
1/19/07	$	850,000	$ 634,745	12/31/13	Varies	$ 22,896	1
							2
							3
							4
							5
							6
							7
							8
	$	850,000	$ 634,745			$ 22,896	9
							10
			Interest Income Offset			(10,144)	11
			Home Office Allocation-PHC			3,431	12
			Home Office Allocation-PHO			22,154	13
	$		$			$ 15,441	14
	$	850,000	$ 634,745			$ 38,337	15

:h. V. $ _____ Line # _____

equently, page 4, col. 7.

in column 2.

Facility Name & ID Number Rock Falls Rehab & HCC

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next works statement and bill must accompany t**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment c

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the li

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other ge
(Describe appeal cost below. Attach copies of invoices to support the cost and a c

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND $ _____ **For** _____ **Tax Year.** **(Attach a copy of the**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	**25,233**	**8**
	2009	**25,560**	**9**
	2010	**26,215**	**10**
	2011	**26,109**	**11**
	2012	**25,740**	**12**

Accrual based on prior year tax bill.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Dec taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you mu application for real estate tax exemption unless the building** **This denial must be no more than four years old at**

sheet, "RE_Tax". The real estate tax the cost report.		$ 26,892	1
overs more than one year, detail below.)	2012	$ 25,740	2
		$ (1,152)	3
nes below.)		$ 26,508	4
eneral operating costs on Schedule V, sections A, B or C. copy of the appeal filed with the county.)		$	5
Home Office Allocation real estate tax appeal board's decision.)		$ 202	6
		$ 25,558	7

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

duct any overaccrual of

ust attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TA

FACILITY NAME Rock Falls Rehab & HCC

FACILITY IDPH LICENSE NUMBER 0047530

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provi
cost that applies to the operation of the nursing home in Column D. Real estate ta
home property which is vacant, rented to other organizations, or used for purposes
entered in Column D. Do not include cost for any period other than calendar year

	(A) Tax Index Number	(B) Property Description	
1.	11-27-427-006	Long-Term Care Facility	$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
		TOTALS	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant prop
used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the c
(Generally the real estate tax cost must be allocated to the nursing home based upc

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this s
tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is
documentation . Facilities located in Cook County are required to provide
installment tax bill.

X STATEMENT

COUNTY Whiteside

-8622

ded below. Enter only the portion of the
x applicable to any portion of the nursing
other than long term care must not be
2012.

(C) Total Tax	(D) Tax Applicable to Nursing Home
25,739.92	$ 25,739.92
	$
	$
	$
	$
	$
	$
	$
	$
	$
25,739.92	$ 25,739.92

erty, or property which is not directly

ost allocated to the nursing home.
on sq. ft. of space used.)

statement. Be sure to use the 2012

not considered acceptable tax bill
copies of their original **second**

Facility Name & ID Number Rock Falls Rehab & HCC

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,658 **B. General Construction Type:** Exterior

C. Does the Operating Entity? [X] **(a) Own the Facility** [ ] **(b) Rent from a**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedul

D. Does the Operating Entity? [X] **(a) Own the Equipment** [ ] **(b) Rent equipr**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Sched

E. List all other business entities owned by this operating entity or related to the operating entity that a (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, ind List entity name, type of business, square footage, and number of beds/units available (where applic

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following:

1. Total Amount Incurred:

3. Current Period Amortization:

Nature of Costs:

(Attach a complete schedule detailing the total amount o

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet
1	Facility	49,223
2		
3	TOTALS	49,223

Masonry Frame Masonry Number of Stories 1

ı Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

e XI or Schedule XII-A. See instructions.)

nent from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

lule XI-C or Schedule XII-B. See instructions.)

ıre located on or adjacent to this nursing home's grounds
ependent living facilities, CNA training facilities, etc.)
able).

☐ YES ☒ NO

2. Number of Years Over Which it is Being Amortized:

4. Dates Incurred:

f organization and pre-operating costs.)

	3 Year Acquired	4 Cost	
	2005	$ 21,375	1
			2
		$ 21,375	3

Facility Name & ID Number Rock Falls Rehab & HCC

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	
4	57		2005	1972	$
5					
6					
7					
8					
	Improvement Type**				
9	Original Land			2005	
10	Sidewalks			2006	
11	Sprinkler			2006	
12	Tile Floor			2006	
13	Gutters			2007	
14	Lighting			2007	
15	Sprinkler Head Installation			2009	
16	Water Heater			2009	
17	Water Line Repair			2010	
18	Sidewalks			2011	
19	Copper Line Installation			2012	
20	Generator			2012	
21	Air Conditoner			2013	
22					
23					
24					
25					
26					
27					
28					
29					
30	Land Improvements Booked				
31	Building Booked				
32	Building Improvement Booked				
33					
34	2013-Home Office Allocation-Building Improvements				
35	2013-Home Office Allocation-Land Improvements				
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.

STATE OF ILLINOIS

 # 0047530 Report Period Beginning: 1/1/2013 Ending:

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
273,764	$	25	$ 10,951	$ 10,951	$
12,000		15	800	800	
10,700		15	713	713	
1,071		25	43	43	
1,916		20	96	96	
3,166		20	158	158	
1,352		15	90	90	
6,913		15	460	460	
3,537		5	707	707	
7,599		7	1,086	1,086	
3,825		15	256	256	
4,959		7	708	708	
62,040		15	4,036	4,036	
3,593		7	257	257	
	1,768			(1,768)	
	15,041			(15,041)	
	7,527			(7,527)	
5,990			144	144	
559			36	36	

See Page 12A, Line 70 for total

9 ccumulated epreciation	
82,131	4
	5
	6
	7
	8
6,800	9
5,348	10
322	11
720	12
1,027	13
585	14
2,070	15
3,005	16
3,801	17
640	18
1,062	19
6,104	20
257	21
	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

Facility Name & ID Number Rock Falls Rehab & HCC

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Improvement Type**	3 Year Constructed	
37			$
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70	TOTAL (lines 4 thru 69)		$

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

STATE OF ILLINOIS

0047530 Report Period Beginning: 1/1/2013 Ending:

) Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
	$		$	$	$
402,984	$ 24,336		$ 20,541	$ (3,795)	$

9 ccumulated epreciation	
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
	52
	53
	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66
	67
	68
	69
113,872	70

Facility Name & ID Number Rock Falls Rehab & HCC # 0047530

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	
71	Purchased in Prior Years	$ 29,076	$
72	Current Year Purchases		
73	Fully Depreciated Assets	80,959	
74	Home Office Allocation		
75	TOTALS	$ 110,035	$

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost
76				$
77				
78				
79				
80	TOTALS			$

E. Summary of Care-Related Assets

		Re
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B th
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B th
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B th
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B th

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	$ 34,418
87				
88				
89				
90				
91	TOTALS	$ 100,861	$ 4,049	$ 34,418

Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
2,214	$ 2,743	$ 529	5-10 yrs.	$ 20,910	71
					72
				80,959	73
	2,022	2,022			74
2,214	$ 4,765	$ 2,551		$ 101,869	75

Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
$	$	$		$	76
					77
					78
					79
$	$	$		$	80

1 eference	2 Amount		
(Pages 12B thru 12I, if applicable)	$ 534,394	81	
ru 12I, if applicable)	$ 26,550	82	
ru 12I, if applicable)	$ 25,306	83	**
ru 12I, if applicable)	$ (1,244)	84	
ru 12I, if applicable)	$ 215,741	85	

G. Construction-in-Progress

		Description	Cost	
86	92		$	92
87	93	N/A		93
88	94			94
89	95		$	95
90				
91				

* 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.

STA

Facility Name & ID Number Rock Falls Rehab & HCC #

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, c
   If NO, see instructions. ☐

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

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

9. Option to Buy: ☐ YES ☐ NO Terms:

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

15. Is Movable equipment rental included in building rental? ☐
16. Rental Amount for movable equipment: $ 8,192 Description: See A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17	Facility	2006 Ford E250 Van	$ 578.16	$
18				
19				
20				
21	TOTAL		$ 578.16	$

column 4?
YES ☐ NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		7

*

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.	/2014	$
13.	/2015	$
14.	/2016	$

YES ☒ NO
Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
6,938	17
	18
	19
	20
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 Rehab & HCC
0047530
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	598
Dishwasher		712
Laundry Equipment		-
Copier		6,510
Home Office Allocation		372
		8,192

Facility Name & ID Number Rock Falls Rehab & HCC

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

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 PO
IN-HOUSE PROG
IN OTHER FACII
COMMUNITY CC
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS

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

(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.

tructions.)

edule listing the facility name, address and cost per CNA trained in that facility.)

RTION:		3. CLINICAL PORTION:	
RAM	☐	IN-HOUSE PROGRAM	☐
LITY	☐	IN OTHER FACILITY	☐
OLLEGE	☐	HOURS PER CNA	____
	____		

(d)

3	4
Contract	Total
	$
	$

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	

(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 Rehab & HCC**

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

		1	2	
	Service	Schedule V Line & Column Reference	Staff Units of Service	
1	Licensed Occupational Therapist	10A(3)	hrs	$
2	Licensed Speech and Language Development Therapist	10A(3)	hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist	10A(3)	hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program		hrs	
8	Habilitation		hrs	
9	Pharmacy	39(2)	# of prescrpts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitio Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with tl on this schedule.

STATE OF ILLINOIS
0047530 Report Period Beginning: 1/1/2013 Ending:

3	4	5	6	7	
Cost	Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	To
	Units	Cost	Allocated)	(Column 2 + 4)	(Col.
	1,286	$ 19,296	$	1,286	$
	105	1,569		105	
	1,425	21,382		1,425	
			12,169		
	2,816	$ 42,247	$ 12,169	2,816	$

ners. Consultant fees should be detailed on
he above activities should not be listed

8	
tal Cost . 3 + 5 + 6)	
19,296	1
1,569	2
	3
21,382	4
	5
	6
	7
	8
12,169	9
	10
	11
	12
	13
54,416	14

Facility Name & ID Number Rock Falls Rehab & HCC **STATE #**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (60,155)	$ (60,155)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 29,000)	461,765	461,765	3
4	Supply Inventory (priced at)	7,395	7,395	4
5	Short-Term Investments			5
6	Prepaid Insurance	26,962	26,962	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 435,967	$ 435,967	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	279,754	14
15	Leasehold Improvements, at Historical Cost	96,146	123,230	15
16	Equipment, at Historical Cost	110,035	110,035	16
17	Accumulated Depreciation (book methods)	(264,003)	(215,741)	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.		66,443	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 364,703	$ 385,096	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 800,670	$ 821,063	25

***(See in**

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 363,349	$ 363,349	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,570	19,570	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,484	4,484	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,508	26,508	32
33	Accrued Interest Payable	1,732	1,732	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	30,720	30,720	36
37	Accrued Management Fees	185,088	185,088	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 631,451	$ 631,451	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	634,745	634,745	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	14,356	14,356	43
44	Intercompany Loans	614,999	614,999	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,264,100	$ 1,264,100	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,895,551	$ 1,895,551	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,094,881)	$ (1,074,488)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 800,670	$ 821,063	48

ıstructions.)

Facility Name & ID Number Rock Falls Rehab & HCC #

XVI. STATEMENT OF CHANGES IN EQUITY

1	**Balance at Beginning of Year, as Previously Reported**	**$**
2	Restatements (describe):	
3	**Rounding**	
4		
5		
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	**$**
	A. Additions (deductions):	
7	NET Income (Loss) (from page 19, line 43)	
8	Aquisitions of Pooled Companies	
9	Proceeds from Sale of Stock	
10	Stock Options Exercised	
11	Contributions and Grants	
12	Expenditures for Specific Purposes	
13	Dividends Paid or Other Distributions to Owners	**(**
14	Donated Property, Plant, and Equipment	
15	Other (describe)	
16	Other (describe)	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	**$**
	B. Transfers (Itemize):	
18		
19		
20		
21		
22		
23	**TOTAL Transfers (sum of lines 18-22)**	**$**
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	**$**

1 Total		
(998,483)	1	
	2	
1	3	
	4	
	5	
(998,482)	6	
(96,399)	7	
	8	
	9	
	10	
	11	
	12	
)	13	
	14	
	15	
	16	
(96,399)	17	
	18	
	19	
	20	
	21	
	22	
	23	
(1,094,881)	24	*

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

STATE OF ILLINOI

Facility Name & ID Number Rock Falls Rehab & HCC # 0047530

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this sched
classifications of revenue and expense must be provided on this form, even if financial statem
Note: This schedule should show gross revenue and expenses. Do not net revenue

		1		
	I. Revenue	**Amount**		
	A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	$ 1,732,610	1	31
2	Discounts and Allowances for all Levels	(53,715)	2	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,678,895	3	33
	B. Ancillary Revenue			
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy	67,131	6	35
7	Oxygen		7	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,131	8	
	C. Other Operating Revenue			37
9	Payments for Education		9	38
10	Other Government Grants		10	39
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals	2,958	14	41
15	Telephone, Television and Radio	1,695	15	
16	Rental of Facility Space		16	42
17	Sale of Drugs	29,122	17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray	1,041	20	
21	Other Medical Services	1,109	21	44
22	Laundry		22	45
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,925	23	46
	D. Non-Operating Revenue			47
24	Contributions		24	48
25	Interest and Other Investment Income***	10,144	25	49
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,144	26	
	E. Other Revenue (specify):**			*
27	**Settlement Income (Insurance, Legal, Etc.)**		27	**
28	**Miscellaneous and Transportation Revenue**	10,836	28	
28a	**Private Revenue - Arrowwood (Expense Offset)**	134,329	28a	***
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 145,165	29	
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,937,260	30	****]

Report Period Beginning: 1/1/2013 **Ending:** 12/31/2013

ule to Schedules V and VI.) All required
ents are attached.
e against expense.

	2	
II. Expenses	**Amount**	
A. Operating Expenses		
General Services	525,924	31
Health Care	752,668	32
General Administration	485,474	33
B. Capital Expense		
Ownership	89,560	34
C. Ancillary Expense		
Special Cost Centers	73,332	35
Provider Participation Fee	106,701	36
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 2,033,659	40
Income before Income Taxes (line 30 minus line 40)**	(96,399)	41
Income Taxes		42
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (96,399)	43

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	$ 1,243,700	44
Private Pay - Net Inpatient Revenue	310,293	45
Medicare - Net Inpatient Revenue	126,014	46
Other-(specify) **Charity Therapy Allowance**	(1,112)	47
Other-(specify)		48
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,678,895	49

This must agree with page 4, line 45, column 4.
Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Rehab & HCC #

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
1	Director of Nursing	1,986	2,034	$ 70,225	$ 34.53
2	Assistant Director of Nursing				
3	Registered Nurses	4,556	4,694	123,510	26.31
4	Licensed Practical Nurses	6,185	6,618	145,494	21.98
5	CNAs & Orderlies	24,071	24,884	251,584	10.11
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides				
9	Activity Director	1,267	1,267	16,095	12.70
10	Activity Assistants	38	38	508	13.37
11	Social Service Workers	1,261	1,335	18,625	13.95
12	Dietician				
13	Food Service Supervisor	2,036	2,036	29,942	14.71
14	Head Cook				
15	Cook Helpers/Assistants	8,940	9,438	88,107	9.34
16	Dishwashers				
17	Maintenance Workers	2,097	2,097	34,142	16.28
18	Housekeepers	8,041	8,608	87,955	10.22
19	Laundry	1,693	1,893	17,621	9.31
20	Administrator	2,080	2,080	79,134	38.05
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager	1,884	1,890	23,098	12.22
24	Clerical				
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records				
32	Other Health Care(specify)				
33	Other(specify) Transportation	86	86	829	9.64
34	TOTAL (lines 1 - 33)	66,221	68,998	$ 986,869 *	$ 14.30

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

** See instructions.

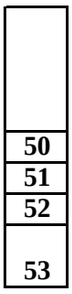
B. CONSULTANT SERVICES

			1	2	3
			Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
1					
2	35	Dietary Consultant	27	$ 1,368	L1, C3
3	36	Medical Director	Monthly	16,800	L9, C3
4	37	Medical Records Consultant			
5	38	Nurse Consultant			
6	39	Pharmacist Consultant	Monthly	2,568	L10, C3
7	40	Physical Therapy Consultant			
8	41	Occupational Therapy Consultant			
9	42	Respiratory Therapy Consultant			
10	43	Speech Therapy Consultant			
11	44	Activity Consultant			
12	45	Social Service Consultant			
13	46	Other(specify)			
14	47				
15	48				
16					
17	49	TOTAL (lines 35 - 48)	27	$ 20,736	
18					
19					
20					

C. CONTRACT NURSES

			1	2	3
21					
22			Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
23					
24					
25					
26					
27	50	Registered Nurses	48	$ 1,298	L10, C3
28	51	Licensed Practical Nurses			
29	52	Certified Nurse Assistants/Aides			
30					
31	53	TOTAL (lines 50 - 52)	48	$ 1,298	
32					
33					
34					


35
36
37
38
39
40
41
42
43
44
45
46
47
48
49


50
51
52
53

Facility Name & ID Number Rock Falls Rehab & HCC

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	$ 209,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 209,800

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 6,763
Comcast Cable	Computer Services	1,774
Gail and Rice	Accounting Services	614
Honkamp Krueger	Accounting Services	484
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,635

STATE OF ILLINOIS
0047530 Report Period Beginning: 1/1/2013

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,540
Unemployment Compensation Insurance	31,700
FICA Taxes	68,310
Employee Health Insurance	16,425
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,842
Employee Retirement	(14)
TOTAL (agree to Schedule V, line 22, col.8)	$ 158,803

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and P

Description
IDPH License Fee
Advertising: Employee Recruitme
Health Care Worker Background
(Indicate # of checks performed
Patient Background Checks
Miscellaneous Licenses & Permits
Miscellaneous Dues & Subscriptio
Home Office Allocation
Less: Public Relations Expense
Non-allowable advertising
Yellow page advertising
TOTAL (agree to Sch. line 20, col. 8)

G. Schedule of Travel and Semina

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

* Attach copy of IMRF notifications

**See instructions.

romotions

		Amount
	$	1,990
nt		
Check		
)		
124		1,242
		200
ns		600
		865
		(600)
	(	)
	(	)
V,	$	4,297

r**

		Amount
	$	
		3
	(	)
	$	3

Rock Falls Rehab & HCC
0047530
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		9,635
Home Office Allocation		
SmithAmundsen	Legal	315
Cole, Schotz, Meisel	Legal	173
Black, Hedin, Ballard	Legal	16
Elias, Meginnes, Riffle & Seghetti	Legal	32
Miller, Hall, and Triggs	Legal	662
Evapar	Legal	128
Ginoli & Company	Accountants	1821
E-Health Data Solutions	Computer Services	2265
Miscellaneous	Computer Services	46
Odessian LLC	Computer Services	25
CCH	Computer Services	7
Lexis-Nexis	Computer Services	3
Ipanema Solutions	Computer Services	7
Macquarie Technology Services	Computer Services	45
Advanced Answers on Demand	Computer Services	2330
TeamViewer	Computer Services	8
Stratus Networks	Computer Services	188
Kemper Technology	Computer Services	145
AT&T	Computer Services	3
Medifax	Computer Services	21
Vision Share/Ability Network	Computer Services	319
Barracuda	Computer Services	57
CIAN	Computer Services	77
Comcast	Computer Services	17
Emdeon	Computer Services	26
Marotta Gund Budd & Dzera	Other Prof Fees	56868
David Budde	Other Prof Fees	15
Pharmacy Price Mangement	Other Prof Fees	293
All Scripts	Other Prof Fees	522
Registered Agent Solutions	Other Prof Fees	25
Healthink	Other Prof Fees	162
Total (agree to Schedule V, line 19, column 8)		76,256

STATE OF IL

Facility Name & ID Number Rock Falls Rehab & HCC #

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in S

(See instructions.)

	1	2	3	4	5	6	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	
1			$		$	$	$
2							
3							
4	N/A						
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20	TOTALS		$		$	$	$

Sch. V, line 6, col. 3).

7	8	9	10	11	12	13
	Amount of Expense Amortized Per Year					
FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
	$	$	$	$	$	$
	$	$	$	$	$	$

Facility Name & ID Number **Rock Falls Rehab & HCC**

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. $ **12,628** 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. $ **106,701**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,958**

(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. $ **8,285**

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 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 **1/1/2013**
Period End **12/31/2013**

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**
Independent Living	3,500	21.55%
Nursing Home	12,740	78.45%
	16,240	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**
Dietary	126,483	21.55%	27,257
Food	106,764	21.55%	23,008
Housekeeping	104,819	21.55%	22,588
Laundry	31,953	21.55%	6,886
Utilities	90,241	21.55%	19,447
Maintenance	65,664	21.55%	14,151
Depreciation (Building)	4,049	100.00%	4,049
Total	529,973		117,386

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

Basis For Allocation	Line
Census	1
Census	2
Census	3
Census	4
Census	5
Census	6
Beds	30

ɛndent Living