

		FOR OHF USE				

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**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0045286</u></p> <p><b>Facility Name:</b> <u>Rockford Health Care Center</u></p> <p><b>Address:</b> <u>310 Arnold Street</u> <u>Rockford</u> <u>61108</u> Number City Zip Code</p> <p><b>County:</b> <u>Winnebago</u></p> <p><b>Telephone Number:</b> <u>(818) 398-7654</u> Fax # <u>(818) 399-0473</u></p> <p><b>IDPA ID Number:</b> <u>36-4416521001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>05/01/2001</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b> Name: <u>Christopher Murphy BKD, LLP</u> Telephone Number: <u>(918) 584-2900</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) <u>Bretton J. Bolt</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>Chief Financial Officer, Nexion Health, Inc.</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) <u>Christopher Murphy Senior Manager</u></td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name &amp; Address) <u>BKD, LLP 1 West Third Street, Suite 1700, Tulsa, Oklahoma 74103</u></td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) <u>(918) 584-2900</u> Fax # <u>(918) 584-2931</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)		(Type or Print Name) <u>Bretton J. Bolt</u>		(Title) <u>Chief Financial Officer, Nexion Health, Inc.</u>	Paid Preparer	(Signed) _____ (Date)		(Print Name and Title) <u>Christopher Murphy Senior Manager</u>		(Firm Name & Address) <u>BKD, LLP 1 West Third Street, Suite 1700, Tulsa, Oklahoma 74103</u>		(Telephone) <u>(918) 584-2900</u> Fax # <u>(918) 584-2931</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Rockford Health Care Center

# 0045286 Report Period Beginning: 05/01/2001 Ending: 12/31/2001

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	0	0	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	77	Intermediate (ICF)	77	18,865	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	77	TOTALS	77	18,865	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	0	0	
9	SNF/PED	0	0	0	9	
10	ICF	15,775	631	29	16,435	10
11	ICF/DD	0	0	0	11	
12	SC	0	0	0	12	
13	DD 16 OR LESS	0	0	0	13	
14	TOTALS	15,775	631	29	16,435	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.12%

D. How many bed-hold days during this year were paid by Public Aid? 250 (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)

N/A - None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 05/01/2001

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/2001 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED   
CASH\*  CASH\*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number Rockford Health Care Center # 0045286 Report Period Beginning: 05/01/2001 Ending: 12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	87,539	7,302	4,104	98,945		98,945		98,945		1
2	Food Purchase		81,120		81,120		81,120		81,120		2
3	Housekeeping	48,143	9,530		57,673		57,673		57,673		3
4	Laundry	25,658	7,911		33,569		33,569		33,569		4
5	Heat and Other Utilities			30,410	30,410		30,410		30,410		5
6	Maintenance	20,999	7,192	21,778	49,969		49,969	5,868	55,837		6
7	Other (specify):* Infectious waste remo			983	983		983		983		7
8	<b>TOTAL General Services</b>	<b>182,339</b>	<b>113,055</b>	<b>57,275</b>	<b>352,669</b>		<b>352,669</b>	<b>5,868</b>	<b>358,537</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	654,004	39,680	11,432	705,116		705,116		705,116		10
10a	Therapy	277	34		311		311		311		10a
11	Activities	21,768	2,119	1,008	24,895		24,895		24,895		11
12	Social Services	26,166	148	1,008	27,322		27,322		27,322		12
13	Nurse Aide Training										13
14	Program Transportation			137	137		137		137		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>702,215</b>	<b>41,981</b>	<b>20,785</b>	<b>764,981</b>		<b>764,981</b>		<b>764,981</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	41,453			41,453		41,453		41,453		17
18	Directors Fees										18
19	Professional Services			107,008	107,008		107,008	30,341	137,349		19
20	Dues, Fees, Subscriptions & Promotions			16,449	16,449	1,296	17,745	916	18,661		20
21	Clerical & General Office Expenses	57,521	14,830	25,577	97,928		97,928	(20,036)	77,892		21
22	Employee Benefits & Payroll Taxes			218,069	218,069	(1,296)	216,773	8,542	225,315		22
23	Inservice Training & Education			1,963	1,963		1,963		1,963		23
24	Travel and Seminar			2,483	2,483		2,483	15,982	18,465		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,812	81,812		81,812	492	82,304		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>98,974</b>	<b>14,830</b>	<b>453,361</b>	<b>567,165</b>		<b>567,165</b>	<b>36,237</b>	<b>603,402</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>983,528</b>	<b>169,866</b>	<b>531,421</b>	<b>1,684,815</b>		<b>1,684,815</b>	<b>42,105</b>	<b>1,726,920</b>		<b>29</b>

\*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 &amp; ID Number

Rockford Health Care Center

#0045286

Report Period Beginning:

05/01/2001

Ending:

12/31/2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,566	6,566		6,566		6,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,813	48,813		48,813		48,813			32
33	Real Estate Taxes			15,646	15,646		15,646		15,646			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>H. O. Capital Costs</b>							18,981	18,981			36
37	<b>TOTAL Ownership</b>			71,025	71,025		71,025	18,981	90,006			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,810		9,810		9,810		9,810			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,529	30,529		30,529		30,529			42
43	Other (specify):* <b>Lab &amp; Rad</b>			645	645		645		645			43
44	<b>TOTAL Special Cost Centers</b>		9,810	31,174	40,984		40,984		40,984			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	983,528	179,676	633,620	1,796,824		1,796,824	61,086	1,857,910			45

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

**VI. ADJUSTMENT DETAIL** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

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

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$ #VALUE!	#####	31
32	Donated Goods-Attach Schedule*	#VALUE!	#####	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	#####	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	#####	34
35	Other- Attach Schedule	#VALUE!	#####	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ #VALUE!		36
(sum of SUBTOTALS				
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ #VALUE!		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			X			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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Rockford Health Care Center

ID# \_\_\_\_\_

Report Period Beginning: 05/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	#VALUE!	\$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	#VALUE!	#VALUE!	#VALUE!	30
31	#VALUE!	#VALUE!	#VALUE!	31
32	#VALUE!	#VALUE!	#VALUE!	32
33				33
34	#VALUE!	#VALUE!	#VALUE!	34
35				35
36				36
37	#VALUE!	#VALUE!	#VALUE!	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	<b>Total</b>	#VALUE!		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rockford Health Care Center# 0045286

Report Period Beginning:

05/01/2001

Ending:

12/31/2001

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	5,868	0	0	0	0	0	0	0	0	5,868	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	5,868	0	0	0	0	0	0	0	0	5,868	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,341	0	0	0	0	0	0	0	0	0	30,341	19
20	Fees, Subscriptions & Promotions	0	916	0	0	0	0	0	0	0	0	0	916	20
21	Clerical & General Office Expenses	0	55,472	(75,508)	0	0	0	0	0	0	0	0	(20,036)	21
22	Employee Benefits & Payroll Taxes	0	6,931	1,611	0	0	0	0	0	0	0	0	8,542	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	15,982	0	0	0	0	0	0	0	0	0	15,982	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	492	0	0	0	0	0	0	0	0	0	492	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	110,134	(73,897)	0	0	0	0	0	0	0	0	36,237	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	110,134	(68,029)	0	0	0	0	0	0	0	0	42,105	29



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Nexion Health, Inc.	100.00	See Attached				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	21 Salaries and Wages	\$	Nexion Health, Inc.	100.00%	\$ 49,136	\$ 49,136 1
2	V	22 PR Taxes & WC		Nexion Health, Inc.	100.00%	3,854	3,854 2
3	V	22 Employee Benefits		Nexion Health, Inc.	100.00%	3,077	3,077 3
4	V	20 Advertising		Nexion Health, Inc.	100.00%	138	138 4
5	V	24 Travel & Seminars		Nexion Health, Inc.	100.00%	15,982	15,982 5
6	V	19 Fees-Professional Services		Nexion Health, Inc.	100.00%	30,341	30,341 6
7	V	20 Fees-Other		Nexion Health, Inc.	100.00%	778	778 7
8	V	21 Office Supplies		Nexion Health, Inc.	100.00%	6,323	6,323 8
9	V	36 Rental & Lease		Nexion Health, Inc.	100.00%	6,586	6,586 9
10	V	36 Depreciation		Nexion Health, Inc.	100.00%	470	470 10
11	V	36 Interest		Nexion Health, Inc.	100.00%	11,925	11,925 11
12	V	21 Ad Valorem Property Tax		Nexion Health, Inc.	100.00%	13	13 12
13	V	26 Insurance-Other		Nexion Health, Inc.	100.00%	492	492 13
14	Total		\$			\$ 129,115	\$ * 129,115 14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	6	Operations & Maintenance	\$		100.00%	\$ 5,868	\$ 5,868	15
16	V	22	Employee Hiring / Moving			100.00%	1,611	1,611	16
17	V	21	Management Fees	75,508		100.00%		(75,508)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 75,508			\$ 7,479	\$ * (68,029)	39

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

Facility Name & ID Number      Rockford Health Care Center      #      0045286      Report Period Beginning:      05/01/2001      Ending:      12/31/2001

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

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

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

Facility Name & ID Number Rockford Health Care Center # 0045286 Report Period Beginning: 05/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Nexion Health, Inc.  
 Street Address 1430 Progress Way, Suite 108  
 City / State / Zip Code Eldersburg, MD 21784  
 Phone Number ( 410) 552-4815  
 Fax Number ( 410) 552-4837

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Salaries and Wages	247789	21	\$ 1,672,659	\$ 601,697	20235	\$ 49,136	1
2	22	PR Taxes & WC	247789	21	1,672,659	601,697	20235	3,854	2
3	22	Employee Benefits	247789	21	1,672,659	601,697	20235	3,077	3
4	20	Advertising	247789	21	1,672,659	601,697	20235	138	4
5	24	Travel & Seminars	247789	21	1,672,659	601,697	20235	15,982	5
6	19	Fees-Professional Services	247789	21	1,672,659	601,697	20235	30,341	6
7	20	Fees-Other	247789	21	1,672,659	601,697	20235	778	7
8	21	Office Supplies	247789	21	1,672,659	601,697	20235	6,323	8
9	36	Rental & Lease	247789	21	1,672,659	601,697	20235	6,586	9
10	36	Depreciation	247789	21	1,672,659	601,697	20235	470	10
11	36	Interest	247789	21	1,672,659	601,697	20235	11,925	11
12	21	Ad Valorem Property Tax	247789	21	1,672,659	601,697	20235	13	12
13	26	Insurance-Other	247789	21	1,672,659	601,697	20235	492	13
14	6	Operations & Maintenance	247789	21	1,672,659	601,697	20235	5,868	14
15	22	Employee Hiring / Moving	247789	21	1,672,659	601,697	20235	1,611	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 25,089,885	\$ 9,025,455		\$ 136,594	25

Facility Name & ID Number Rockford Health Care Center # 0045286 Report Period Beginning: 05/01/2001 Ending: 12/31/2001

## 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	
						Original	Balance					
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
	YES	NO										
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Nationwide Health Properties	X	Bridge Loan	None - N/A	12/21/01	\$ 1,000,000	\$ 1,000,000	12/21/02	11.0000	\$ 3,315	1	
2									-		2	
3									-		3	
4									-		4	
5											5	
<b>Working Capital</b>												
6	Heller	X	Working Capital	N/A	N/A	N/A	167,509	None	Various	45,498	6	
7											7	
8											8	
9	TOTAL Facility Related					\$ 1,000,000	\$ 1,167,509			\$ 48,813	9	
<b>B. Non-Facility Related*</b>												
10											10	
11											11	
12											12	
13											13	
14	TOTAL Non-Facility Related					\$	\$			\$	14	
15	TOTALS (line 9+line14)					\$ 1,000,000	\$ 1,167,509			\$ 48,813	15	

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

(See instructions.)

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

(See instructions.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 24,371	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.)		\$ 16,369	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (8,002)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 23,648	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 15,646	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	23,099	8
	1997	23,793	9
	1998	24,032	10
	1999	23,847	11
	2000	16,369	12
	<b>FOR OHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Rockford Health Care Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0045286

CONTACT PERSON REGARDING THIS REPORT Christopher Murphy BKD, LLP

TELEPHONE (918) 584-2900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>172A-144</u>	<u>Nursing Facility</u>	\$ <u>23,122.68</u>	\$ <u>23,122.68</u>
2. <u>172A-145</u>	<u>Nursing Facility</u>	\$ <u>431.20</u>	\$ <u>431.20</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>23,553.88</u>	\$ <u>23,553.88</u>

**B. Real Estate Tax Cost Allocation:**

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

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

**C. Tax Bills**

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 18,384 B. General Construction Type: Exterior Block / Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	72,156	2001	\$ 71,400	1
2					2
3	<b>TOTALS</b>	72,156		\$ 71,400	3

Facility Name & ID Number Rockford Health Care Center

# 0045286

Report Period Beginning:

05/01/2001 Ending: 12/31/2001

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	81	2001		\$ 208,600	\$ 2,670	25	\$ 2,670		\$ 2,670	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	heat patches for parking lot and entrance	2001		1,400	47	5	47		47	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
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$	-	\$	\$	\$		37
38					-					38
39					-					39
40					-					40
41					-					41
42					-					42
43					-					43
44					-					44
45					-					45
46					-					46
47					-					47
48					-					48
49					-					49
50					-					50
51					-					51
52					-					52
53					-					53
54					-					54
55					-					55
56					-					56
57					-					57
58					-					58
59					-					59
60					-					60
61					-					61
62					-					62
63	(DON'T ENTER BELOW THIS LINE)									63
64	Total (This Page)									64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 210,000	\$ 2,717		\$ 2,717	\$	\$ 2,717		70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	28,844	3,849	3,849		Various	3,849	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 28,844	\$ 3,849	\$ 3,849	\$		\$ 3,849	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 310,244	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,566	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,566	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,566	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 0 Description: N/A

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>Training was not necessary for aides, as the facility only hired aides who were already trained.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aide 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 aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					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	10, 3	# of prescripts			Monthly Fee	5,214		-				5,214	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$			5,214	\$				\$	5,214	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 nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number      Rockford Health Care Center

#      0045286

Report Period Beginning:    05/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of    12/31/2001

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,820	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	393,298		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,676		7
8	Accounts Receivable (owners or related parties)	(40,793)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 425,001	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	72,800		13
14	Buildings, at Historical Cost	208,600		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	28,844		16
17	Accumulated Depreciation (book methods)	(6,566)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 303,678	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 728,679	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 43,727	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(519)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,973		30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,431)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,648		32
33	Accrued Interest Payable	3,315		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<b>Management Fee Payable</b>	91,898		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 232,611	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	167,509		39
40	Mortgage Payable	1,000,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Intercompany Payable</b>	(373,015)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 794,494	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,027,105	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (298,426)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 728,679	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(298,426)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (298,426)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (298,426)</b>	<b>24</b> *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number Rockford Health Care Center

# 0045286

Report Period Beginning: 05/01/2001

Ending:

Page 19  
12/31/2001**VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,788,791	1
2	Discounts and Allowances for all Levels	(298,951)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,489,840	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,265	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,978	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,243	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,315	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,315	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,498,398	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	352,669	31
32	Health Care	764,981	32
33	General Administration	567,165	33
<b>B. Capital Expense</b>			
34	Ownership	71,025	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	10,455	35
36	Provider Participation Fee	30,529	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,796,824	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(298,426)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (298,426)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 &amp; ID Number Rockford Health Care Center

# 0045286

Report Period Beginning: 05/01/2001

Ending: 12/31/2001

## 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
2	Assistant Director of Nursing				2
3	Registered Nurses	3,076	69,414	21.68	3
4	Licensed Practical Nurses	10,569	202,063	19.12	4
5	Nurse Aides & Orderlies	27,690	364,648	12.04	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	964	8,177	8.48	9
10	Activity Assistants	1,464	13,590	8.41	10
11	Social Service Workers	1,583	26,166	15.10	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	10,599	87,539	7.97	15
16	Dishwashers				16
17	Maintenance Workers	1,399	20,999	14.04	17
18	Housekeepers	6,451	48,143	7.15	18
19	Laundry	3,901	25,658	6.19	19
20	Administrator	1,296	41,453	31.99	20
21	Assistant Administrator				21
22	Other Administrative	3,578	57,522	14.22	22
23	Office Manager				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	1,309	18,156	12.73	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	73,879	\$ 983,528 *	\$ 12.53	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	170	\$ 4,104	1, 3	35
36	Medical Director	Monthly Fee	7,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,008	11, 3	44
45	Social Service Consultant	18	1,008	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 13,320		49

## C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	19	\$ 563	10, 3	50
51	Licensed Practical Nurses	32	876	10, 3	51
52	Nurse Aides	451	4,763	10, 3	52
53	TOTAL (lines 50 - 52)	502	\$ 6,203		53





Facility Name & ID Number Rockford Health Care Center# 0045286Report Period Beginning: 05/01/2001Ending: 12/31/2001

## 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. N/A
- (3) Did the nursing home make political contributions or payments to a political 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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,647 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 of Public Aid during this cost report period. \$ 30,529  
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 of Public Aid, 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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.