

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

<p>I. IDPH License ID Number: <u>0047530</u></p> <p>Facility Name: <u>Rock Falls Rehabilitation & Health Care Center</u></p> <p>Address: <u>430 Martin Road, PO Box 579</u> <u>Rock Falls</u> <u>61071</u> <small>Number City Zip Code</small></p> <p>County: <u>Whiteside</u></p> <p>Telephone Number: <u>(815) 626-4575</u> Fax # <u>(815) 626-8264</u></p> <p>HFS ID Number: <u>20-3224201041</u></p> <p>Date of Initial License for Current Owners: <u>10/01/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u> </u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other <u> </u></td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 691-8113</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	IRS Exemption Code <u> </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Mark B. Petersen</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) _____</td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Mark B. Petersen</u>		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) _____																																						

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center

0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	12,610	3,006		15,616	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,610	3,006		15,616	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.06%

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 NO

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 10/01/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/01/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	105,303	13,217	1,806	120,326		120,326	(34,217)	86,109		1
2	Food Purchase		119,968		119,968		119,968	(37,208)	82,760		2
3	Housekeeping	82,282	14,097		96,379		96,379	(29,911)	66,468		3
4	Laundry	27,233	12,173		39,406		39,406	(12,235)	27,171		4
5	Heat and Other Utilities			88,411	88,411		88,411	(27,229)	61,182		5
6	Maintenance	35,749	9,597	18,738	64,084		64,084	(18,065)	46,019		6
7	Other (specify):* Home Off. Ben. All.							2,129	2,129		7
8	TOTAL General Services	250,567	169,052	108,955	528,574		528,574	(156,736)	371,838		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	533,497	18,565	1,110	553,172		553,172	5,614	558,786		10
10a	Therapy			1,194	1,194		1,194		1,194		10a
11	Activities	18,654	939	452	20,045		20,045		20,045		11
12	Social Services	22,994			22,994		22,994		22,994		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,565	2,565		15
16	TOTAL Health Care and Programs	575,145	19,504	9,256	603,905		603,905	8,179	612,084		16
	C. General Administration										
17	Administrative	53,835		33,000	86,835		86,835	(15,766)	71,069		17
18	Directors Fees										18
19	Professional Services			8,675	8,675		8,675	4,809	13,484		19
20	Dues, Fees, Subscriptions & Promotions			7,607	7,607		7,607	270	7,877		20
21	Clerical & General Office Expenses	27,670	3,008	11,712	42,390		42,390	23,822	66,212		21
22	Employee Benefits & Payroll Taxes			125,582	125,582		125,582		125,582		22
23	Inservice Training & Education			759	759		759	255	1,014		23
24	Travel and Seminar			50	50		50	405	455		24
25	Other Admin. Staff Transportation			4,914	4,914		4,914	2,642	7,556		25
26	Insurance-Prop.Liab.Malpractice			13,561	13,561		13,561	598	14,159		26
27	Other (specify):* Home Off. Ben. All.							12,594	12,594		27
28	TOTAL General Administration	81,505	3,008	205,860	290,373		290,373	29,629	320,002		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	907,217	191,564	324,071	1,422,852		1,422,852	(118,928)	1,303,924		29

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

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

Facility Name & ID Number

Rock Falls Rehabilitation & Health Care Center

#0047530

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			32,673	32,673		32,673	(2,029)	30,644		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			62,227	62,227		62,227	35,799	98,026		32
33	Real Estate Taxes			27,040	27,040		27,040	511	27,551		33
34	Rent-Facility & Grounds							31	31		34
35	Rent-Equipment & Vehicles			5,860	5,860		5,860	411	6,271		35
36	Other (specify):*										36
37	TOTAL Ownership			127,800	127,800		127,800	34,723	162,523		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			31,208	31,208		31,208		31,208		42
43	Other (specify):* Non-allowable Cost	1,634	281	10,592	12,507		12,507	(12,507)			43
44	TOTAL Special Cost Centers	1,634	281	41,800	43,715		43,715	(12,507)	31,208		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	908,851	191,845	493,671	1,594,367		1,594,367	(96,712)	1,497,655		45

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

**See schedule of adjustments attached at end of cost report.

Rock Falls Rehabilitation & Health Care CenterID# 0047530Report Period Beginning: 01/01/2007Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Food Revenue	\$ (3)	2	1
2	Offset Miscellaneous Office Supplies Revenue	(438)	21	2
3	Nonallowable Dues	(351)	20	3
4	Independent Living depreciation offset	(4,049)	30	4
5	Independent Living - Dietary	(37,361)	1	5
6	Independent Living - Food	(37,250)	2	6
7	Independent Living - Housekeeping	(29,926)	3	7
8	Independent Living - Laundry	(12,236)	4	8
9	Independent Living - Utilities	(27,452)	5	9
10	Independent Living - Maintenance	(19,898)	6	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
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	(168,964)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(37,361)	1,307	0	1,837	0	0	0	0	0	0	0	(34,217)	1
2	Food Purchase	(37,253)	45	0	0	0	0	0	0	0	0	0	(37,208)	2
3	Housekeeping	(29,926)	15	0	0	0	0	0	0	0	0	0	(29,911)	3
4	Laundry	(12,236)	1	0	0	0	0	0	0	0	0	0	(12,235)	4
5	Heat and Other Utilities	(27,452)	223	0	0	0	0	0	0	0	0	0	(27,229)	5
6	Maintenance	(19,898)	1,820	0	13	0	0	0	0	0	0	0	(18,065)	6
7	Other (specify):*	0	596	0	1,533	0	0	0	0	0	0	0	2,129	7
8	TOTAL General Services	(164,126)	4,007	0	3,383	0	(156,736)	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,455	0	2,159	0	0	0	0	0	0	0	5,614	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	768	0	1,797	0	0	0	0	0	0	0	2,565	15
16	TOTAL Health Care and Program	0	4,223	0	3,956	0	8,179	16						
	C. General Administration													
17	Administrative	0	(23,272)	0	7,506	0	0	0	0	0	0	0	(15,766)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,641	0	2,168	0	0	0	0	0	0	0	4,809	19
20	Fees, Subscriptions & Promotions	(351)	0	572	49	0	0	0	0	0	0	0	270	20
21	Clerical & General Office Expenses	(438)	0	22,150	2,110	0	0	0	0	0	0	0	23,822	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	255	0	0	0	0	0	0	0	0	255	23
24	Travel and Seminar	0	0	405	0	0	0	0	0	0	0	0	405	24
25	Other Admin. Staff Transportation	0	0	1,469	1,173	0	0	0	0	0	0	0	2,642	25
26	Insurance-Prop.Liab.Malpractice	0	0	598	0	0	0	0	0	0	0	0	598	26
27	Other (specify):*	0	0	6,333	6,261	0	0	0	0	0	0	0	12,594	27
28	TOTAL General Administration	(789)	(20,631)	31,782	19,267	0	29,629	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(164,915)	(12,401)	31,782	26,606	0	(118,928)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	(4,466)	0	1,551	886	0	0	0	0	0	0	0	(2,029) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	2,696	33,103	0	0	0	0	0	0	0	35,799 32
33	Real Estate Taxes	0	0	511	0	0	0	0	0	0	0	0	511 33
34	Rent-Facility & Grounds	0	0	31	0	0	0	0	0	0	0	0	31 34
35	Rent-Equipment & Vehicles	0	0	411	0	0	0	0	0	0	0	0	411 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(4,466)	0	5,200	33,989	0	34,723 37						
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(12,507)	0	0	0	0	0	0	0	0	0	0	(12,507) 43
44	TOTAL Special Cost Centers	(12,507)	0	0	0	0	0	0	0	0	0	0	(12,507) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(181,888)	(12,401)	36,982	60,595	0	(96,712) 45						

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
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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	Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,307	\$	1,307	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	45		45	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	15		15	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1		1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	223		223	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,820		1,820	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	596		596	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,455		3,455	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0			9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	768		768	10
11	V	17 Administrative	33,000	Petersen Health Care, Inc.	100.00%	9,728		(23,272)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,641		2,641	12
13	V								13
14	Total		\$ 33,000			\$ 20,599	\$ *	(12,401)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20	Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 572	\$ 572	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	22,150	22,150	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	255	255	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	405	405	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,469	1,469	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	598	598	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,333	6,333	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,551	1,551	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,696	2,696	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	511	511	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	31	31	25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	411	411	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		\$				\$ 36,982	\$ * 36,982	39

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 <u>Dietary</u>	\$	<u>Petersen Health Operations, LLC</u>	100.00%	\$ 1,837	\$ 1,837	15
16	V	2 <u>Food</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	17
18	V	4 <u>Laundry</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	18
19	V	5 <u>Utilities</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Operations, LLC</u>	100.00%	13	13	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,533	1,533	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Operations, LLC</u>	100.00%	2,159	2,159	22
23	V	10A <u>Therapy</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,797	1,797	24
25	V	17 <u>Administrative</u>		<u>Petersen Health Operations, LLC</u>	100.00%	7,506	7,506	25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Operations, LLC</u>	100.00%	2,168	2,168	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Operations, LLC</u>	100.00%	49	49	27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Operations, LLC</u>	100.00%	2,110	2,110	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,173	1,173	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	6,261	6,261	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Operations, LLC</u>	100.00%	886	886	34
35	V	32 <u>Interest</u>		<u>Petersen Health Operations, LLC</u>	100.00%	33,103	33,103	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0	0	38
39	Total		\$			\$ 60,595	\$ * 60,595	39

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Ce # 0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.64	1.16	Salary	\$ 9,728	L17, C7	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	\$ 9,728		13

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 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

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	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	15,616	\$ 1,307	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	15,616	45	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	15,616	15	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	15,616	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	15,616	223	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	15,616	1,820	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	15,616	596	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	15,616	3,455	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	15,616	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	15,616	768	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	15,616	9,728	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	15,616	2,641	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	15,616	572	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	15,616	22,150	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	15,616	255	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	15,616	405	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	15,616	1,469	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	15,616	598	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	15,616	6,333	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	15,616	1,551	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	15,616	2,696	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	15,616	511	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	15,616	31	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	15,616	411	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 57,581	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	15,616	\$ 1,837	1
2	2	Food	Resident Days	440,525	23			15,616		2
3	3	Housekeeping	Resident Days	440,525	23			15,616		3
4	4	Laundry	Resident Days	440,525	23			15,616		4
5	5	Utilities	Resident Days	440,525	23			15,616		5
6	6	Maintenance	Resident Days	440,525	23	358		15,616	13	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		15,616	1,533	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	15,616	2,159	8
9	10A	Therapy	Resident Days	440,525	23			15,616		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		15,616	1,797	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	15,616	7,506	11
12	19	Professional Services	Resident Days	440,525	23	61,162		15,616	2,168	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		15,616	49	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		15,616	2,110	14
15	23	Inservice Training & Education	Resident Days	440,525	23			15,616		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		15,616		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		15,616	1,173	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			15,616		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		15,616	6,261	19
20	30	Depreciation	Resident Days	440,525	23	24,996		15,616	886	20
21	32	Interest	Resident Days	440,525	23	933,842		15,616	33,103	21
22	33	Real Estate Taxes	Resident Days	440,525	23			15,616		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			15,616		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			15,616		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 60,595	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 850,000	\$ 844,296	12/31/13	Varies	\$ 62,227	1				
2												2				
3												3				
4							Home Office Allocation				35,799	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 850,000	\$ 844,296			\$ 98,026	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 850,000	\$ 844,296			\$ 98,026	15				

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

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

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2006 report.				\$	25,600	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.)		2006		\$	25,640	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	40	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	27,000	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	511	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	27,551	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2002	_____	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2003	_____	9																						
	2004	_____	10																						
	2005	25,439	11																						
	2006	25,640	12																						
Accrual based on prior year tax bill.																									

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Falls Rehabilitation & Health Care Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0047530

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

	(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>11-27-427-006</u>	<u>Long-Term Care Facility</u>	<u>\$ 25,639.58</u>	<u>\$ 25,639.58</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
		TOTALS	<u>\$ 25,639.58</u>	<u>\$ 25,639.58</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Independent Living

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	<u>Facility</u>	<u>49,223</u>	<u>2005</u>	<u>\$ 21,375</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	49,223		\$ 21,375	3

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	57		2005	1972	\$ 273,764	\$	25	\$ 10,951	\$ 10,951	\$ 27,376
5										
6										
7		Home Office Allocation			8,706			213	213	
8										
		Improvement Type**								
9										
10		Original Land	2005		12,000		15	800	800	2,000
11		Sidewalks	2006		10,700		15	713	713	1,070
12		Sprinkler	2006		1,071		25	43	43	64
13		Tile Floor	2006		1,916		20	96	96	144
14		Gutters	2007		3,166		20	79	79	79
15		Lighting	2007		1,352		15	45	45	45
16										
17										
18										
19		Land Improvements Booked				1,514			(1,514)	
20		Building Booked				15,041			(15,041)	
21		Building Improvements Booked				200			(200)	
22										
23										
24										
25										
26										
27										
28										
29										
30										
31		2007-Home Office Allocation-Building Improvements			583			35	35	
32										
33										
34										
35										
36										

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 313,258	\$ 16,755		\$ 12,975	\$ (3,780)	\$ 30,778	70

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 86,705	\$ 14,094	\$ 14,314	\$ 220	6-7	\$ 34,633	71
72	Current Year Purchases	23,330	1,824	1,166	(658)	10	1,166	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,189	2,189			74
75	TOTALS	\$ 110,035	\$ 15,918	\$ 17,669	\$ 1,751		\$ 35,799	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)	\$ 444,668	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,673	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,644	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,029)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 66,577	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living (2005)	\$ 100,861	\$ 4,049	\$ 10,124	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 100,861	\$ 4,049	\$ 10,124	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		Home Office Allocation			31			6
7	TOTAL				\$ 31			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,271

Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Rock Falls Rehabilitation & Health Care Center
0047530

Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 4,265
Dishwasher	728
Laundry Equipment	
Medical Equipment	867
Home Office Allocation	411
	<u>6,271</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	80	\$ 1,194			\$	80	\$ 1,194	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts					0				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			\$	80	\$ 1,194			\$	80	\$ 1,194	14

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

Facility Name & ID Number **Rock Falls Rehabilitation & Health Care Center**# **0047530**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2007**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 321,117	\$ 321,117	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	339,680	339,680	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,481	11,481	6
7	Other Prepaid Expenses	2,045	2,045	7
8	Accounts Receivable (owners or related parties)	(42,123)	(42,123)	8
9	Other(specify):	3,250	3,250	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 635,450	\$ 635,450	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		21,375	13
14	Buildings, at Historical Cost	418,700	283,053	14
15	Leasehold Improvements, at Historical Cost	7,505	30,205	15
16	Equipment, at Historical Cost	110,035	110,035	16
17	Accumulated Depreciation (book methods)	(68,126)	(66,577)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 468,114	\$ 378,091	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,103,564	\$ 1,013,541	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 135,393	\$ 135,393	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,792	17,792	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,959	6,959	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,000	27,000	32
33	Accrued Interest Payable	5,277	5,277	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholding Liabilities	16,503	16,503	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 208,924	\$ 208,924	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	844,296	844,296	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Dep/Due from prior owner	33,772	33,772	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 878,068	\$ 878,068	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,086,992	\$ 1,086,992	46
47	TOTAL EQUITY (page 18, line 24)	\$ 16,572	\$ (73,451)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,103,564	\$ 1,013,541	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,272	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(20,049)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,777)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	24,349	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 24,349	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 16,572	24 *

* This must agree with page 17, line 47.

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 01/01/2007Ending: 12/31/2007**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,618,275	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,618,275	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	438	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 438	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,618,716	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	528,574	31
32	Health Care	603,905	32
33	General Administration	290,373	33
B. Capital Expense			
34	Ownership	127,800	34
C. Ancillary Expense			
35	Special Cost Centers	12,507	35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,594,367	40
41	Income before Income Taxes (line 30 minus line 40)**	24,349	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 24,349	43

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

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

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center

0047530

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

12/31/2007

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 54,497	\$ 26.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,590	2,590	56,949	21.99	3
4	Licensed Practical Nurses	6,800	6,979	129,595	18.57	4
5	CNAs & Orderlies	27,918	28,626	251,749	8.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,957	2,117	18,654	8.81	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,120	22,994	10.85	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,284	12.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,525	10,737	79,019	7.36	15
16	Dishwashers					16
17	Maintenance Workers	2,964	3,021	35,749	11.83	17
18	Housekeepers	11,043	11,290	82,282	7.29	18
19	Laundry	3,693	3,792	27,233	7.18	19
20	Administrator	1,821	1,821	53,835	29.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,941	2,114	27,670	13.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	2,080	2,080	40,707	19.57	32
33	Other(specify) <u>Marketing</u>	126	126	1,634	12.97	33
34	TOTAL (lines 1 - 33)	79,698	81,573	\$ 908,851 *	\$ 11.14	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	35	\$ 1,806	L 1, C 3	35
36	Medical Director	Monthly	6,500	L 9, C 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,040	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	35	\$ 9,346		49

C. CONTRACT NURSES

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

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

**XIX. SUPPORT SCHEDULE
C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,675

Non-allowable legal expense

**Home Office Allocation
Petersen Health Care, Inc**

Pearl & Associates	Legal	17
Addy Bush & Assoc	Legal	9
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	38
Duane Morris	Legal	59
Ginoli & Co.	Accountants	604
RSM McGladrey	Accountants	105
McGladrey & Pullen	Accountants	159
Emdeon Business Services	Computer Services	41
Advanced Answers on Demand	Computer Services	1,120
Access 2 Go	Computer Services	84
Ivans	Computer Services	74
Kemper Technology	Computer Services	176
Adminastar Federal	Computer Services	22
Logmeln	Computer Services	14
E-Health Data Solutions	Computer Services	110
Miscellaneous Vendors	Miscellaneous	8

Petersen Health Operations, LLC

Ginoli & Co.	Accountants	1,341
Julie Breedlove	Computer Services	13
Ivans	Computer Services	301
Miscellaneous Vendors	Computer Services	5
Amerisearch	Employment fees	508

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>13,484</u>
--	---------------

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530Report Period Beginning: 01/01/2007 Ending: 12/31/2007**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? Yes
If YES, give association name and amount. IHCA \$2043
- (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. \$ 5,508 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. \$ 31,208
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes, See Sch. 23A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3
- (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? 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? 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? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Rock Falls Rehabilitation & Health Care Center
 0047530
 Period Beginning 01/01/2007
 Period End 12/31/2007

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%	Beds	%
Independent Living	7,033	31.05%	21	26.92%
Nursing Home	15,616	68.95%	57	73.08%
	<u>22,649</u>	<u>100.00%</u>	<u>78</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	120,326	31.05%	37,361	Census	1
Food	119,968	31.05%	37,250	Census	2
Housekeeping	96,379	31.05%	29,926	Census	3
Laundry	39,406	31.05%	12,236	Census	4
Utilities	88,411	31.05%	27,452	Census	5
Maintenance	64,084	31.05%	19,898	Census	6
Depreciation (Building)	<u>15,041</u>	26.92%	<u>4,049</u>	Beds	30
Total	<u>543,615</u>		<u>168,172</u>		

Building Cost Offset:

P12 Building Cost	374,625	26.92%	100,849	Beds
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Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
 Independent Living overhead and depreciation cost have been offset on P5A.