

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

0047530 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	20,862	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,786	2,525		13,311	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,786	2,525		13,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.81%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 10/1/05

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

YES Date 10/1/05 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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number

Rock Falls Rehabilitation & Health Care Cen

0047530

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	115,428	12,149	498	128,075		128,075	(42,985)	85,090		1
2	Food Purchase		114,436		114,436		114,436	(41,403)	73,033		2
3	Housekeeping	92,595	14,585		107,180		107,180	(37,935)	69,245		3
4	Laundry	29,452	9,476		38,928		38,928	(13,783)	25,145		4
5	Heat and Other Utilities			93,830	93,830		93,830	(32,980)	60,850		5
6	Maintenance	36,015	7,890	20,408	64,313		64,313	(20,600)	43,713		6
7	Other (specify):* Home Off. Ben. All.							806	806		7
8	TOTAL General Services	273,490	158,536	114,736	546,762		546,762	(188,880)	357,882		8
	B. Health Care and Programs										
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	552,030	20,610	852	573,492		573,492	4,106	577,598		10
10a	Therapy										10a
11	Activities	18,719	126	400	19,245		19,245		19,245		11
12	Social Services	19,928	15		19,943		19,943	6	19,949		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							717	717		15
16	TOTAL Health Care and Programs	590,677	20,751	20,752	632,180		632,180	4,829	637,009		16
	C. General Administration										
17	Administrative	63,753		104,000	167,753		167,753	(84,137)	83,616		17
18	Directors Fees										18
19	Professional Services			4,500	4,500		4,500	3,943	8,443		19
20	Dues, Fees, Subscriptions & Promotions			4,538	4,538		4,538	322	4,860		20
21	Clerical & General Office Expenses	26,869	2,400	6,359	35,628		35,628	26,341	61,969		21
22	Employee Benefits & Payroll Taxes			211,397	211,397		211,397		211,397		22
23	Inservice Training & Education			1,160	1,160		1,160	150	1,310		23
24	Travel and Seminar							150	150		24
25	Other Admin. Staff Transportation			3,880	3,880		3,880	5,183	9,063		25
26	Insurance-Prop.Liab.Malpractice			16,934	16,934		16,934	111	17,045		26
27	Other (specify):* Home Off. Ben. All.							7,601	7,601		27
28	TOTAL General Administration	90,622	2,400	352,768	445,790		445,790	(40,336)	405,454		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	954,789	181,687	488,256	1,624,732		1,624,732	(224,387)	1,400,345		29

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

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

Facility Name & ID Number

Rock Falls Rehabilitation & Health Care Center

#0047530

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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			34,033	34,033		34,033	(1,191)	32,842		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			55,159	55,159		55,159	8,515	63,674		32
33	Real Estate Taxes			23,649	23,649		23,649	338	23,987		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			26,492	26,492		26,492	288	26,780		35
36	Other (specify):*										36
37	TOTAL Ownership			139,333	139,333		139,333	7,950	147,283		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			31,295	31,295		31,295		31,295		42
43	Other (specify):* Non-allowable Cost		520	16,036	16,556		16,556	(16,556)			43
44	TOTAL Special Cost Centers		520	47,331	47,851		47,851	(16,556)	31,295		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	954,789	182,207	674,920	1,811,916		1,811,916	(232,993)	1,578,923		45

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

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

0047530

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,890)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(486)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,423)	43		18
19	Entertainment				19
20	Contributions	(3)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,078)	43		24
25	Fund Raising, Advertising and Promotional	(5,047)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(199,287)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,318)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(16,675)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,675)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (232,993)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY						
48		49		50		51
						52

Rock Falls Rehabilitation & Health Care Center

ID# 0047530

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallowed Special Events	(11)	43	1
2	Offset Miscellaneous Food Revenue	(922)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(347)	21	3
4	Offset Chamber of Commerce Dues	(351)	20	4
5	Independent Living depreciation offset	(4,049)	30	5
6	Independent Living - Dietary	(45,351)	1	6
7	Independent Living - Food	(40,522)	2	7
8	Independent Living - Housekeeping	(37,952)	3	8
9	Independent Living - Laundry	(13,784)	4	9
10	Independent Living - Utilities	(33,225)	5	10
11	Independent Living - Maintenance	(22,773)	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(199,287)		49

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,366	\$ 2,366	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	39	39	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	245	245	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,446	1,446	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	582	582	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,106	4,106	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	717	717	10
11	V	17 Administrative	104,000	Petersen Health Care, Inc.	100.00%	18,418	(85,582)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,079	2,079	12
13	V							13
14	Total		\$ 104,000			\$ 30,016	\$ * (73,984)	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%	\$ 641	\$ 641	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	23,113	23,113	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	140	140	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	141	141	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,820	1,820	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	111	111	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,580	6,580	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,518	2,518	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,771	1,771	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	338	338	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	288	288	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		\$				\$ 37,461	\$ * 37,461	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: 1/1/2008Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	2	2	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	727	727	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	224	224	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	6	6	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,445	1,445	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,864	1,864	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	32	32	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	3,575	3,575	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	10	10	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	9	9	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	3,363	3,363	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,021	1,021	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	826	826	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	6,744	6,744	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 19,848	\$ *	19,848	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: 1/1/2008 Ending: 12/31/2008

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	1,810,256	0.55	0.92	Salary	18,418	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	\$ 18,418		13

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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	1,413,604	69	\$ 251,260	\$ 250,687	13,311	\$ 2,366	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	13,311	39	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	13,311	17	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	13,311	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	13,311	245	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	13,311	1,446	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	13,311	582	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	13,311	4,106	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	13,311	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	13,311	717	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	13,311	18,418	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	13,311	2,079	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	13,311	641	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	13,311	23,113	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	13,311	140	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	13,311	141	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	13,311	1,820	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	13,311	111	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	13,311	6,580	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	13,311	2,518	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	13,311	1,771	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	13,311	338	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	13,311	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	13,311	288	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 67,477	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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	419,957	23	\$	\$	13,311	\$	1
2	2	Food	Resident Days	419,957	23	68		13,311	2	2
3	3	Housekeeping	Resident Days	419,957	23			13,311		3
4	4	Laundry	Resident Days	419,957	23			13,311		4
5	5	Utilities	Resident Days	419,957	23			13,311		5
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	13,311	727	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067		13,311	224	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6		13,311		8
9	12	Social Services	Resident Days	419,957	23	187		13,311	6	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	13,311	1,445	10
11	19	Professional Services	Resident Days	419,957	23	58,812		13,311	1,864	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997		13,311	32	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798		13,311	3,575	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23			13,311		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299		13,311	10	15
16	24	Travel and Seminar	Resident Days	419,957	23	296		13,311	9	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105		13,311	3,363	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23			13,311		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211		13,311	1,021	19
20	30	Depreciation	Resident Days	419,957	23	26,070		13,311	826	20
21	32	Interest	Resident Days	419,957	23	212,765		13,311	6,744	21
22	33	Real Estate Taxes	Resident Days	419,957	23			13,311		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23			13,311		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23			13,311		24
25	TOTALS					\$ 626,192	\$ 55,582		\$ 19,848	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 850,000	\$ 834,776	12/31/13	Varies	\$ 55,159	1								
2												2								
3												3								
4							Home Office Allocation-PHC				1,771	4								
5							Home Office Allocation-PHO				6,744	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 850,000	\$ 834,776			\$ 63,674	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	\$ 834,776			\$ 63,674	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

	(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>\$ 24,949.22</u>	<u>\$ 24,949.22</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>\$ 24,949.22</u>	<u>\$ 24,949.22</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

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	
Bed*	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	\$ 38,327
5									
6									
7									
8									
Improvement Type**									
9	Original Land		2005	12,000		15	800	800	2,800
10	Sidewalks		2006	10,700		15	713	713	1,783
11	Sprinkler		2006	1,071		25	43	43	107
12	Tile Floor		2006	1,916		20	96	96	240
13	Gutters		2007	3,166		20	158	158	237
14	Lighting		2007	1,352		15	90	90	135
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28	Building Booked				15,041			(15,041)	
29	Building Improvement Booked				1,814			(1,814)	
30									
31									
32	2008-Home Office Allocation-Land Improvements			462			30	30	
33	2008-Home Office Allocation-Building Improvements			6,911			166	166	
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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 311,342	\$ 16,855		\$ 13,047	\$ (3,808)	\$ 43,629	70

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	\$ 110,036	\$ 17,178	\$ 16,647	\$ (531)	7-10 yrs.	\$ 52,446	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,148	3,148			74
75	TOTALS	\$ 110,036	\$ 17,178	\$ 19,795	\$ 2,617		\$ 52,446	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)	\$ 442,753	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,033	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,842	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,191)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 96,075	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	\$ 14,173	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 100,861	\$ 4,049	\$ 14,173	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,810

Description: See Attached 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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2006 Ford E250 Van</u>	\$ <u>581.00</u>	\$ <u>21,970</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>581.00</u>	\$ <u>21,970</u>	21

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

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

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment-Refund	\$	433
Dishwasher		649
Laundry Equipment		59
Copier		3,381
Home Office Allocation		288
		<u>4,810</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	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		hrs	\$		\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$		\$		\$		\$		14

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

Facility Name & ID Number **Rock Falls Rehabilitation & Health Care Center**# **0047530**Report Period Beginning: **1/1/2008**Ending: **12/31/2008****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2008**

(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	\$ 130,911	\$ 130,911	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	335,945	335,945	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,603	24,603	6
7	Other Prepaid Expenses	8,035	8,035	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Advances	375	375	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 499,869	\$ 499,869	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	280,675	14
15	Leasehold Improvements, at Historical Cost	7,505	30,667	15
16	Equipment, at Historical Cost	110,035	110,036	16
17	Accumulated Depreciation (book methods)	(102,159)	(96,075)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Non-Care Asset-Ind. Lv. Bldg.		100,861	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 434,081	\$ 447,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 933,950	\$ 947,408	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 129,898	\$ 129,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,015	18,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,925	4,925	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,700	25,700	32
33	Accrued Interest Payable	4,166	4,166	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	29,980	29,980	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 212,684	\$ 212,684	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	834,776	834,776	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	21,000	21,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 855,776	\$ 855,776	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,068,460	\$ 1,068,460	46
47	TOTAL EQUITY (page 18, line 24)	\$ (134,510)	\$ (121,052)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 933,950	\$ 947,408	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 16,572	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 16,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(151,082)	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)	\$ (151,082)	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)	\$ (134,510)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2008Ending: 12/31/2008**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	\$ 1,659,565	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,659,565	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	922	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)	\$ 922	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	347	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 347	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,660,834	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	546,762	31
32	Health Care	632,180	32
33	General Administration	445,790	33
B. Capital Expense			
34	Ownership	139,333	34
C. Ancillary Expense			
35	Special Cost Centers	16,556	35
36	Provider Participation Fee	31,295	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,811,916	40
41	Income before Income Taxes (line 30 minus line 40)**	(151,082)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (151,082)	43

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

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

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

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

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

0047530

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	2,151	2,269	\$ 61,365	\$ 27.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,853	1,901	45,721	24.05	3
4	Licensed Practical Nurses	7,505	7,753	149,003	19.22	4
5	CNAs & Orderlies	27,459	28,319	253,928	8.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,923	2,115	18,719	8.85	9
10	Activity Assistants					10
11	Social Service Workers	1733	1,837	19,928	10.85	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,908	12.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,221	11,543	88,520	7.67	15
16	Dishwashers					16
17	Maintenance Workers	2,843	2,843	36,015	12.67	17
18	Housekeepers	10,716	11,127	92,595	8.32	18
19	Laundry	3,582	3,744	29,452	7.87	19
20	Administrator	2,080	2,080	63,753	30.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,064	2,269	26,869	11.84	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	42,013	20.20	33
34	TOTAL (lines 1 - 33)	79,290	81,960	\$ 954,789 *	\$ 11.65	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	9 visits	\$ 498	1(3)	35
36	Medical Director	Monthly	19,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(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)		\$ 20,598		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	8	252	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 252		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carolyn McBride	Administrator	0	\$ 63,753	Workers' Compensation Insurance	\$ 82,567	IDPH License Fee	\$	
				Unemployment Compensation Insurance	32,967	Advertising: Employee Recruitment	464	
				FICA Taxes	71,231	Health Care Worker Background Check		
				Employee Health Insurance	22,546	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	89	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	993	
				Employee Relations	1,603	Miscellaneous Dues & Subscriptions	351	
				Employee Retirement	483	IHCA Dues	1,840	
						Home Office Allocation	673	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,753			Less: Public Relations Expense	(351)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 104,000			TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 4,860	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 104,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 211,397	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Insight Communications	Computer Services		\$ 200				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,600				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	150
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,500	TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 150

* Attach copy of IMRF notifications

**See instructions.

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,500

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	152
GoffWilson, P.A.	Legal	252
Ginoli & Company	Accountants	2,111
RSM McGladrey	Accountants	6
Miscellaneous Vendors	Computer Services	29
Emdeon Business Services	Computer Services	41
Advanced Answers on Demand	Computer Services	478
Access 2 Go	Computer Services	141
Ivans	Computer Services	326
Kemper Technology	Computer Services	259
VisionShare	Computer Services	28
Logmein	Computer Services	20
Comm Net Communiations	Computer Services	7
Charter Communications	Computer Services	6
Advanced System Designs	Computer Services	9
Consolidated Communications	Computer Services	6
Miscellaneous Vendors	Miscellaneous	72

Total (agree to Schedule V, line 19, column 8)		<u>8,443</u>
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Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn McBride	Administrator	0	63,753
	Total		<u>63,753</u>

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 1,840 -IHCA
- (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? No
- (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. \$ 5,384 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? N/A
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. \$ 31,295
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 922
- (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. \$ No
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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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 1/1/2008

Period End 12/31/2008

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%	Beds	%
Independent Living	7,299	35.41%	21	26.92%
Nursing Home	13,311	64.59%	57	73.08%
	<u>20,610</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	128,075	35.41%	45,351	Census	1
Food	114,436	35.41%	40,522	Census	2
Housekeeping	107,180	35.41%	37,952	Census	3
Laundry	38,928	35.41%	13,784	Census	4
Utilities	93,830	35.41%	33,225	Census	5
Maintenance	64,313	35.41%	22,773	Census	6
Depreciation (Building)	<u>15,041</u>	26.92%	<u>4,049</u>	Beds	30
Total	<u>561,803</u>		<u>197,656</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.