



Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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 bedsN/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	<u>177</u>	Skilled (SNF)	<u>177</u>	<u>64,782</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>177</u>	TOTALS	<u>177</u>	<u>64,782</u>	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	<u>1,249</u>		<u>3,432</u>	<u>4,681</u>	8
9	SNF/PED					9
10	ICF	<u>37,826</u>	<u>3,204</u>	<u>629</u>	<u>41,659</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,075</u>	<u>3,204</u>	<u>4,061</u>	<u>46,340</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 71.53%

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)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES  NO 

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

YES  NO 

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

Date started 03/06/1997

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

YES  Date 03/06/1997 NO 

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

YES  NO  If YES, enter number  
of beds certified 177 and days of care provided 3,432Medicare Intermediary National Government Services

## 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	<b>A. General Services</b>										
1	Dietary	197,120	21,216	29,313	247,649		247,649	(14,852)	232,797		1
2	Food Purchase		233,854		233,854	(15,987)	217,867	(162)	217,706		2
3	Housekeeping	164,150	41,325		205,475		205,475		205,475		3
4	Laundry	73,237	27,255	9,845	110,337		110,337		110,337		4
5	Heat and Other Utilities			147,790	147,790		147,790	1,655	149,445		5
6	Maintenance	57,464	35,771	120,636	213,871		213,871	(17,956)	195,915		6
7	Other (specify):*							1,273	1,273		7
8	<b>TOTAL General Services</b>	<b>491,971</b>	<b>359,421</b>	<b>307,584</b>	<b>1,158,976</b>	<b>(15,987)</b>	<b>1,142,989</b>	<b>(30,042)</b>	<b>1,112,948</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,300	24,300		24,300		24,300		9
10	Nursing and Medical Records	1,687,492	170,731	56,948	1,915,171		1,915,171	(35,127)	1,880,044		10
10a	Therapy	86,794		28,800	115,594		115,594	(16,294)	99,300		10a
11	Activities	89,353	9,134		98,487		98,487		98,487		11
12	Social Services	101,630		3,004	104,634		104,634		104,634		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,520	2,520		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,965,269</b>	<b>179,865</b>	<b>113,052</b>	<b>2,258,186</b>		<b>2,258,186</b>	<b>(48,901)</b>	<b>2,209,285</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	65,203		87,096	152,299		152,299	(10,598)	141,701		17
18	Directors Fees										18
19	Professional Services			168,852	168,852		168,852	(110,561)	58,291		19
20	Dues, Fees, Subscriptions & Promotions			72,288	72,288		72,288	(16,849)	55,439		20
21	Clerical & General Office Expenses	109,515	35,090	154,135	298,740		298,740	(53,508)	245,232		21
22	Employee Benefits & Payroll Taxes			331,154	331,154	15,987	347,141		347,141		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,788	5,788		5,788	371	6,159		24
25	Other Admin. Staff Transportation			9,572	9,572		9,572	5,941	15,513		25
26	Insurance-Prop.Liab.Malpractice			133,142	133,142		133,142	649	133,791		26
27	Other (specify):*							26,440	26,440		27
28	<b>TOTAL General Administration</b>	<b>174,718</b>	<b>35,090</b>	<b>962,027</b>	<b>1,171,835</b>	<b>15,987</b>	<b>1,187,822</b>	<b>(158,115)</b>	<b>1,029,707</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,631,958</b>	<b>574,376</b>	<b>1,382,663</b>	<b>4,588,997</b>		<b>4,588,997</b>	<b>(237,057)</b>	<b>4,351,940</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Island Nursing & Rehab Center #0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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
	<b>D. Ownership</b>										
30	Depreciation			36,166	36,166	36,166	10,549	46,715			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			64,705	64,705	64,705	5,434	70,139			32
33	Real Estate Taxes						4,082	4,082			33
34	Rent-Facility & Grounds			599,940	599,940	599,940	(50,396)	549,544			34
35	Rent-Equipment & Vehicles			26,321	26,321	26,321	4,771	31,092			35
36	Other (specify):*						26,631	26,631			36
37	<b>TOTAL Ownership</b>			727,132	727,132	727,132	1,071	728,203			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	58,151	177,423	183,529	419,103	419,103		419,103			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			89,209	89,209	89,209		89,209			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>	58,151	177,423	272,738	508,312	508,312		508,312			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,690,109	751,799	2,382,533	5,824,441	5,824,441	(235,986)	5,588,455			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,245	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	(162)	02		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				18
19	Entertainment				19
20	Contributions	(1,531)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,720)	21		24
25	Fund Raising, Advertising and Promotional	(16,234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(276)	20		28
29	Other-Attach Schedule	(26,261)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (130,939)		\$	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)	(105,048)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (105,048)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (235,986)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Capitalized R&M	\$ (7,018)	06	1
2	Collections	(50)	19	2
3	Non-Allowable Legal Fees	(3,881)	19	3
4	Amortization - Building Company	(5,144)	31	4
5	Fees - Building Company	(5,449)	20	5
6	Office expense - Building Company	(58)	21	6
7	Professional Fees - Building Company	(4,661)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(26,261)		49

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866

Report Period Beginning:

01/01/08

Ending:

12/31/08**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary				(14,852)								(14,852)	1
2	Food Purchase	(162)											(162)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,655									1,655	5
6	Maintenance	(7,018)		(10,938)									(17,956)	6
7	Other (specify):*			576	697								1,273	7
8	<b>TOTAL General Services</b>	<b>(7,180)</b>		<b>(8,707)</b>	<b>(14,155)</b>								<b>(30,042)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(31,230)	5,084	(8,981)							(35,127)	10
10a	Therapy				(16,294)								(16,294)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,178	1,342								2,520	15
16	<b>TOTAL Health Care and Programs</b>			<b>(30,052)</b>	<b>(9,867)</b>	<b>(8,981)</b>							<b>(48,901)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(77,532)	66,934								(10,598)	17
18	Directors Fees													18
19	Professional Services	(8,592)	4,661	(116,366)	9,736								(110,561)	19
20	Fees, Subscriptions & Promotions	(23,490)	5,449	1,192									(16,849)	20
21	Clerical & General Office Expenses	(88,778)	58	31,938	3,274								(53,508)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			371									371	24
25	Other Admin. Staff Transportation			5,941									5,941	25
26	Insurance-Prop.Liab.Malpractice			649									649	26
27	Other (specify):*			11,602	14,838								26,440	27
28	<b>TOTAL General Administration</b>	<b>(120,860)</b>	<b>10,168</b>	<b>(142,205)</b>	<b>94,782</b>								<b>(158,115)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(128,040)</b>	<b>10,168</b>	<b>(180,964)</b>	<b>70,760</b>	<b>(8,981)</b>							<b>(237,057)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	2,245		8,304									10,549	30
31	Amortization of Pre-Op. & Org.	(5,144)	5,144											31
32	Interest		1,686	3,748									5,434	32
33	Real Estate Taxes			4,082									4,082	33
34	Rent-Facility & Grounds		(50,396)										(50,396)	34
35	Rent-Equipment & Vehicles			4,771									4,771	35
36	Other (specify):*		26,631										26,631	36
37	<b>TOTAL Ownership</b>	<b>(2,899)</b>	<b>(16,935)</b>	<b>20,905</b>									<b>1,071</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(130,939)</b>	<b>(6,767)</b>	<b>(160,059)</b>	<b>70,760</b>	<b>(8,981)</b>							<b>(235,986)</b>	<b>45</b>

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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
See Attached		See Attached		See Attached		
				Rock Island Real Estate LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 599,940	Rock Island Real Estate, LLC	100.00%	\$	\$ (599,940)	1
2	V	32 Interest Income	3,995	Rock Island Real Estate, LLC	100.00%		(3,995)	2
3	V	31 Amortization Expense		Rock Island Real Estate, LLC	100.00%	5,144	5,144	3
4	V	20 Fees		Rock Island Real Estate, LLC	100.00%	5,449	5,449	4
5	V	36 Insurance		Rock Island Real Estate, LLC	100.00%	26,631	26,631	5
6	V	32 Interest Expense		Rock Island Real Estate, LLC	100.00%	5,681	5,681	6
7	V	21 Office		Rock Island Real Estate, LLC	100.00%	58	58	7
8	V	19 Professional Fees		Rock Island Real Estate, LLC	100.00%	4,661	4,661	8
9	V	34 Rent-Base		Rock Island Real Estate, LLC	100.00%	280,116	280,116	9
10	V	34 Rent-Escrow		Rock Island Real Estate, LLC	100%	269,428	269,428	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 603,935			\$ 597,168	\$ * (6,767)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/08Ending: 12/31/08

## 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	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,655	\$ 1,655	15
16	V	6 REPAIRS AND MAINT.	19,116	S.I.R. MANAGEMENT, INC.	100.00%	8,178	(10,938)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	576	576	17
18	V	10 NURSING	38,232	S.I.R. MANAGEMENT, INC.	100.00%	7,002	(31,230)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,178	1,178	19
20	V	17 ADMINISTRATIVE	77,532	S.I.R. MANAGEMENT, INC.	100.00%		(77,532)	20
21	V	19 PROFESSIONAL FEES	129,444	S.I.R. MANAGEMENT, INC.	100.00%	13,078	(116,366)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,192	1,192	22
23	V	21 CLERICAL & GENERAL	38,232	S.I.R. MANAGEMENT, INC.	100.00%	70,170	31,938	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	371	371	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,941	5,941	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	649	649	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	11,602	11,602	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,304	8,304	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,748	3,748	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,082	4,082	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,771	4,771	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 302,556			\$ 142,497	\$ * (160,059)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/08Ending: 12/31/08

## 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 SALARIES	\$ 19,116	S.I.R. MANAGEMENT, INC.	100.00%	\$ 4,264	\$ (14,852)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	697	697	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,084	5,084	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	806	806	18
19	V	17	ADMIN./LEGAL SALARIES	9,564	S.I.R. MANAGEMENT, INC.	100.00%	76,498	66,934	19
20	V	21	CLERICAL & OFFICE SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,274	3,274	20
21	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	9,736	9,736	21
22	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	14,838	14,838	22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	19,116	S.I.R. MANAGEMENT, INC.	100.00%	2,822	(16,294)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	536	536	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 47,796				\$ 118,556	\$ * 70,760	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	101,396	Xcel Supply, LLC	100.00%	92,415	(8,981)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 101,396			\$ 92,415	\$ * (8,981)	39

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

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	Bryan Barrish	Relative	Administrative	N/A	See Attached	1.72	4.30%	Alloc. Salary	\$ 11,161	17-7	1
2	Michael Giannini	Relative	Administrative	N/A	See Attached	2.00	5.00%	Alloc. Salary	11,161	17-7	2
3	Eric Rothner	Relative	Administrative	N/A	See Attached	0.40	0.87%	Alloc. Salary	6,294	17-7	3
4	Nenita Guzman	Relative	Dietary	1.13%	See Attached	2.86	5.72%	Alloc. Salary	4,264	1-7	4
5	Patricia McDiarmid	Member	Administrative	1.13%	See Attached	2.86	5.72%	Alloc. Salary	6,744	17-7	5
6	Louise Bergthold	Member	Administrative	1.13%	See Attached	3.15	5.73%	Alloc. Salary	11,161	17-7	6
7	Tom Winter	Member	Administrative	5.65%	See Attached	3.43	5.72%	Alloc. Salary	11,161	17-7	7
8	Jeff Oravec	Member	Administrative	1.13%	See Attached	2.29	5.73%	Alloc. Sal/Fees	7,060	17-7	8
9	Sarah Barrish	Relative	Administrative	0.00%	See Attached	0.32	5.79%	Alloc. Salary	823	17-7	9
10	Ronald Nunziatio	Member	Administrative	1.13%	See Attached	2.29	5.73%	Alloc. Salary	6,179	17-7	10
11	Andrew Chin	Relative	Clerical	0.00%	See Attached	2.29	5.73%	Alloc. Salary	3,274	21-7	11
12	Fay Chin	Member	Nursing	1.13%	See Attached	2.29	5.73%	Alloc. Salary	5,084	10-7	12
13								TOTAL	\$ 84,366		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

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	5	UTILITIES	PATIENT DAYS	809,665	13	\$ 28,924	\$ 46,340	\$ 1,655	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	809,665	13	142,892	61,135	46,340	8,178	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	809,665	13	10,063		46,340	576	3
4	10	NURSING	PATIENT DAYS	809,665	13	122,335	122,335	46,340	7,002	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	809,665	13	20,583		46,340	1,178	5
6	17	ADMINISTRATIVE	PATIENT DAYS	809,665	13			46,340		6
7	19	PROFESSIONAL FEES	PATIENT DAYS	809,665	13	228,501	152,688	46,340	13,078	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	809,665	13	20,828		46,340	1,192	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	809,665	13	1,226,029	1,066,051	46,340	70,170	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	809,665	13	6,483		46,340	371	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	809,665	13	103,811		46,340	5,941	11
12	26	INSURANCE	PATIENT DAYS	809,665	13	11,341		46,340	649	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	809,665	13	202,715		46,340	11,602	13
14	30	DEPRECIATION	PATIENT DAYS	809,665	13	145,092		46,340	8,304	14
15	32	INTEREST	PATIENT DAYS	809,665	13	65,487		46,340	3,748	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	809,665	13	71,319		46,340	4,082	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	809,665	13	83,368		46,340	4,771	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,489,771	\$ 1,402,210		\$ 142,497	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

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 SALARIES	PATIENT DAYS	809,665	13	\$ 74,508	\$ 74,508	46,340	\$ 4,264	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	809,665	13	12,182		46,340	697	2
3	10	NURSING SALARIES	PATIENT DAYS	809,665	13	88,823	88,823	46,340	5,084	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	809,665	13	14,090		46,340	806	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	809,665	13	1,336,598	1,336,598	46,340	76,498	5
6	21	CLERICAL & OFFICE SALARIES	PATIENT DAYS	809,665	13	57,211	57,211	46,340	3,274	6
7	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	809,665	13	170,103		46,340	9,736	7
8	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	809,665	13	259,260		46,340	14,838	8
9										9
10	10A	DIRECTOR OF SPECIAL REHAB	SPECIAL REHAB INC.	268,263	13	39,604	39,604	19,116	2,822	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	268,263	13	7,528		19,116	536	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	TOTALS					\$ 2,059,907	\$ 1,596,744		\$ 118,556	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	Direct Allocation			\$		\$	1
2	3	Housekeeping	Direct Allocation						2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					92,415	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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	TOTALS					\$		\$	92,415

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Cambridge/Heartland		X	Mortgage		11/2003	\$ 5,141,900	\$	12/2033		\$ 5,681	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	<b>Working Capital</b>											
6	Lake Forest Bank & Trust		X	Line of Credit				1,710,000			35,449	6
7	Shareholder Loan		X					210,000			29,256	7
8	See Supplemental Schedule										3,748	8
9	TOTAL Facility Related						\$ 5,141,900	\$ 1,920,000			\$ 74,134	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income - Bldg Co.		X								(3,995)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(3,995)	14
15	TOTALS (line 9+line14)						\$ 5,141,900	\$ 1,920,000			\$ 70,139	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,631 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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						
		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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	<b>TOTAL Long-Term</b>											7						
	<b>Working Capital</b>																	
8	Allocated From SIR Mgmt		X				\$	\$			\$	3,748	8					
9												9						
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>											14						
	<b>B. Non-Facility Related*</b>																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>											20						

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$	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.)		\$ <b>127,361</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>127,361</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>127,361</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<b>135,986</b>	<b>8</b>
	2004	<b>142,860</b>	<b>9</b>
	2005	<b>131,112</b>	<b>10</b>
	2006	<b>136,536</b>	<b>11</b>
	2007	<b>123,279</b>	<b>12</b>
<b>R/E Tax Expense Included with Rent Expense in 2008 and Is Not Separately Accrued or Expensed</b>			
<b>Allocated to SIR - \$4,082</b>			

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Island Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**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>10-341-78-00</u>	<u>Long Term Care Property</u>	\$ <u>121,889.16</u>	\$ <u>121,889.16</u>
2. <u>10-341-78-00</u>	<u>Long Term Care Property</u>	\$ <u>1,390.32</u>	\$ <u>1,390.32</u>
3. <u>See Attached</u>	<u>Related Party Allocation</u>	\$ <u>101,615.67</u>	\$ <u>4,183.32</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>224,895.15</u>	\$ <u>127,462.80</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? X YES        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.

**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 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 the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 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 Office of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Rock Island Nursing & Rehab Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

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

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 54,494 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 + Basement

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>224,770</u>	<u>1997</u>	<u>\$ 420,000</u>	1
2					2
3	<b>TOTALS</b>	<b>224,770</b>		<b>\$ 420,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

**See Page 12A, Line 70 for total**

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Related Building Company (Pages 12-BLDG &amp; 12A-BLDG)</b>								67
68	<b>Related Party Allocations (Pages 12-REP &amp; 12A-REP)</b>		59,334	2,188		2,481	293	25,997	68
69	<b>Financial Statement Depreciation</b>			36,166			(36,166)		69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 59,334	\$ 38,354		\$ 2,481	\$ (35,873)	\$ 25,997	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 59,334	\$ 38,354		\$ 2,481	\$ (35,873)	\$ 25,997	1
2	Water Heater	2008	6,570		20	1,205	1,205	1,205	2
3	Nurse Station	2008	19,200		20	800	800	800	3
4	Floor Work	2008	75,693		20	3,154	3,154	3,154	4
5	Ceiling Tile	2008	35,437		20	2,658	2,658	2,658	5
6	Draperies	2008	42,557		20	2,837	2,837	2,837	6
7	Painting	2008	226,884		20	7,563	7,563	7,563	7
8	Doors	2008	3,291		20	27	27	27	8
9	Buffet Line	2008	23,281		20	970	970	970	9
10	Compressor	2008	5,717		20	476	476	476	10
11	Handrails	2008	156,327		20	3,908	3,908	3,908	11
12	Buffet Line Work	2008	8,570		20	214	214	214	12
13	A/C Units	2008	4,386		20	219	219	219	13
14	Heat/Cool Units	2008	2,632		20	132	132	132	14
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 669,878	\$ 38,354		\$ 26,644	\$ (11,710)	\$ 50,160	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
<b>1</b>	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>1</b>
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<b>34</b>	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
<b>1</b>	<b>Totals from Page 12F, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>1</b>
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33									33
<b>34</b>	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
2									2
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
2									2
3									3
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12K, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
2									2
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12M, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
<b>1</b>	<b>Totals from Page 12N, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>1</b>
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<b>34</b>	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
<b>1</b>	<b>Totals from Page 12O, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>1</b>
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
<b>34</b>	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	
1	<b>Totals from Page 12P, Carried Forward</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>669,878</b>	\$ <b>38,354</b>		\$ <b>26,644</b>	\$ <b>(11,710)</b>	\$ <b>50,160</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	<b>TOTAL (lines 4 thru 69)</b>		\$	\$	\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocate From SIR Properties - SIR Mgmt	1993	1993	\$ 23,795	\$ 755	35	\$ 680	\$ (75)	\$ 10,538	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Allocate From SIR - Management	1993	1993	6,568	183	20	326	143	5,210	9
10		Allocate From SIR - Management	1994	1994	20	-	20	-		20	10
11		Allocate From SIR - Management	1995	1995	150	-	20	7	7	101	11
12		Allocate From SIR - Management	1997	1997	10,093	226	20	505	279	5,959	12
13		Allocate From SIR - Management	1999	1999	794	-	20	40	40	367	13
14		Allocate From SIR - Management	2000	2000	937	-	20	47	47	400	14
15		Allocate From SIR - Management	2007	2007	3,010	-	20	151	151	180	15
16		Allocate From SIR - Management	2008	2008	8,297	633	20	442	(191)	442	16
17											17
18		Allocated From SIR Properties - SIR Mgmt	1993	1993	386	2	20	19	17	299	18
19		Allocated From SIR Properties - SIR Mgmt	1994	1994	227	6	20	11	5	164	19
20		Allocated From SIR Properties - SIR Mgmt	1997	1997	90	-	20	4	4	56	20
21		Allocated From SIR Properties - SIR Mgmt	1998	1998	1,441	-	20	72	72	756	21
22		Allocated From SIR Properties - SIR Mgmt	1999	1999	3,015	302	20	151	(151)	1,432	22
23		Allocated From SIR Properties - SIR Mgmt	2002	2002	94	-	20	5	5	31	23
24		Allocated From SIR Properties - SIR Mgmt	2007	2007	417	81	20	21	(60)	42	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rock Island Nursing & Rehab Center**

# **0049866**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			59,334	2,188	2,481	293	25,997	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 45,308	\$ 5,268	\$ 4,537	\$ (731)	10	\$ 12,002	71
72	Current Year Purchases	220,422	848	15,534	14,686	10	15,534	72
73	Fully Depreciated Assets	27,932				10	27,929	73
74								74
75	TOTALS	\$ 293,662	\$ 6,116	\$ 20,071	\$ 13,955		\$ 55,465	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)	\$ 1,383,540	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,470	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,715	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,245	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 105,625	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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:		177		\$ 549,544			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		177		\$ 549,544			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 27,311 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From SIR Management		\$ _____	\$ 3,781	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ 3,781	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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 89,186	\$		\$ 89,186	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,620			3,620	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			90,723			90,723	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				108,041		108,041	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>			58,151			69,382		127,533	13
14	TOTAL			\$ 58,151		\$ 183,529	\$ 177,423		\$ 419,103	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 8,342	\$ 13,184	1
2	Cash-Patient Deposits	51,291	97,791	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,014,796	2,014,796	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		1,180,000	5
6	Prepaid Insurance	2,771	9,701	6
7	Other Prepaid Expenses	415	415	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,077,615	\$ 3,315,887	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	541,769	541,769	15
16	Equipment, at Historical Cost	297,052	297,052	16
17	Accumulated Depreciation (book methods)	(39,472)	(39,472)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,144)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	62,942	62,942	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 862,291	\$ 882,866	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,939,906	\$ 4,198,753	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 594,348	\$ 594,348	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,906	51,906	28
29	Short-Term Notes Payable	1,920,000	1,920,000	29
30	Accrued Salaries Payable	84,426	84,426	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,989	16,989	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>		46,310	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,667,669	\$ 2,713,979	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,667,669	\$ 2,713,979	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 272,237	\$ 1,484,774	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,939,906	\$ 4,198,753	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>10,952</b>	1
2	Restatements (describe):		2
3	<b>Capital Contribution</b>	<b>177,000</b>	3
4	<b>Other Adjustments</b>	<b>30,515</b>	4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>218,467</b>	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	<b>53,770</b>	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>53,770</b>	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>272,237</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/08Ending: 12/31/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,729,373	1
2	Discounts and Allowances for all Levels	(511,189)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,218,184	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	475,940	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 475,940	8
<b>C. Other Operating Revenue</b>			
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,313	19
20	Radiology and X-Ray	1,176	20
21	Other Medical Services	60,937	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 184,087	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,878,211	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,158,976	31
32	Health Care	2,258,186	32
33	General Administration	1,171,835	33
<b>B. Capital Expense</b>			
34	Ownership	727,132	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	419,103	35
36	Provider Participation Fee	89,209	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,824,441	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	53,770	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 53,770	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning: 01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,942	2,083	\$ 55,964	\$ 26.87	1
2	Assistant Director of Nursing	2,046	2,112	48,661	23.04	2
3	Registered Nurses	5,342	5,415	117,397	21.68	3
4	Licensed Practical Nurses	36,756	39,072	680,966	17.43	4
5	CNAs & Orderlies	67,923	68,101	694,558	10.20	5
6	CNA Trainees					6
7	Licensed Therapist	2,384	2,392	58,151	24.31	7
8	Rehab/Therapy Aides	5,291	5,809	86,794	14.94	8
9	Activity Director	1,979	2,022	28,379	14.04	9
10	Activity Assistants	5,902	6,294	60,974	9.69	10
11	Social Service Workers	7,811	8,361	101,630	12.16	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,091	38,130	18.24	13
14	Head Cook	9,250	10,072	92,594	9.19	14
15	Cook Helpers/Assistants	8,550	8,582	66,396	7.74	15
16	Dishwashers					16
17	Maintenance Workers	4,322	4,532	57,464	12.68	17
18	Housekeepers	18,370	19,244	164,150	8.53	18
19	Laundry	8,128	8,579	73,237	8.54	19
20	Administrator	2,041	2,091	65,203	31.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,716	8,178	109,515	13.39	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	5,124	5,488	89,946	16.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	202,870	210,518	\$ 2,690,109 *	\$ 12.78	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	Monthly	\$ 10,197	01-03	35
36	Medical Director	Monthly	24,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	38,232	10-03	38
39	Pharmacist Consultant	Monthly	600	10-03	39
40	Physical Therapy Consultant	269	16,126	10a-03	40
41	Occupational Therapy Consultant	197	11,794	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	880	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	56	3,004	12-03	45
46	Other(specify) <u>Dir. Of Food Service</u>	Monthly	19,116	01-03	46
47	<u>Specialized Services</u>	Monthly	19,116	10-03	47
48	<u>Prior Period Adj.</u>		(1,000)	10-03	48
49	TOTAL (lines 35 - 48)	537	\$ 142,365		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Rock Island Nursing & Rehab Center

Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC - \$ 6104
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,073 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? X YES 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. \$ 89,209  
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. \$ 15,987 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 100% Ln 14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT