

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

0047530 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,069	2,004	920	11,993	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,069	2,004	920	11,993	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.64%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Independent Living

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
 Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Cen # 0047530 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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
	A. General Services										
1	Dietary	119,502	10,167		129,669		129,669	(34,846)	94,823		1
2	Food Purchase		94,032		94,032		94,032	(32,287)	61,745		2
3	Housekeeping	82,507	15,109		97,616		97,616	(27,791)	69,825		3
4	Laundry	28,057	11,363		39,420		39,420	(11,231)	28,189		4
5	Heat and Other Utilities			75,684	75,684		75,684	(21,355)	54,329		5
6	Maintenance	38,924	5,863	21,117	65,904		65,904	(16,585)	49,319		6
7	Other (specify):* Home Off. Ben. All.							379	379		7
8	TOTAL General Services	268,990	136,534	96,801	502,325		502,325	(143,716)	358,609		8
	B. Health Care and Programs										
9	Medical Director			14,550	14,550		14,550		14,550		9
10	Nursing and Medical Records	541,593	24,998	6,371	572,962		572,962	1,244	574,206		10
10a	Therapy										10a
11	Activities	20,812	282	120	21,214		21,214		21,214		11
12	Social Services	21,081			21,081		21,081		21,081		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							156	156		15
16	TOTAL Health Care and Programs	583,486	25,280	21,041	629,807		629,807	1,400	631,207		16
	C. General Administration										
17	Administrative	16,250		137,000	153,250		153,250	(85,992)	67,258		17
18	Directors Fees										18
19	Professional Services			4,481	4,481		4,481	3,760	8,241		19
20	Dues, Fees, Subscriptions & Promotions			7,211	7,211		7,211	1,321	8,532		20
21	Clerical & General Office Expenses	33,184	2,627	9,473	45,284		45,284	22,935	68,219		21
22	Employee Benefits & Payroll Taxes			358,322	358,322		358,322		358,322		22
23	Inservice Training & Education							218	218		23
24	Travel and Seminar							67	67		24
25	Other Admin. Staff Transportation			3,361	3,361		3,361	1,265	4,626		25
26	Insurance-Prop.Liab.Malpractice			32,075	32,075		32,075	437	32,512		26
27	Other (specify):* Home Off. Ben. All.							8,265	8,265		27
28	TOTAL General Administration	49,434	2,627	551,923	603,984		603,984	(47,724)	556,260		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	901,910	164,441	669,765	1,736,116		1,736,116	(190,040)	1,546,076		29

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center #0047530 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			32,238	32,238		32,238	293	32,531			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,322	42,322		42,322	11,284	53,606			32
33	Real Estate Taxes			25,533	25,533		25,533	266	25,799			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,891	13,891		13,891	254	14,145			35
36	Other (specify):*											36
37	TOTAL Ownership			113,984	113,984		113,984	12,097	126,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):* Non-allowable Cost		531	17,638	18,169		18,169	(18,169)				43
44	TOTAL Special Cost Centers		531	48,846	49,377		49,377	(18,169)	31,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	901,910	164,972	832,595	1,899,477		1,899,477	(196,112)	1,703,365			45

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

Rock Falls Rehabilitation & Health Care Center

ID# 0047530

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	(60)	43	1
2	Offset Miscellaneous Food Revenue	(5,544)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(291)	21	3
4	Offset Chamber of Commerce Dues	(351)	20	4
5	Independent Living depreciation offset	(4,049)	30	5
6	Independent Living - Dietary	(36,943)	1	6
7	Independent Living - Food	(26,790)	2	7
8	Independent Living - Housekeeping	(27,811)	3	8
9	Independent Living - Laundry	(11,231)	4	9
10	Independent Living - Utilities	(21,562)	5	10
11	Independent Living - Maintenance	(18,776)	6	11
12	Offset Miscellaneous Nursing Supplies Revenue	(25)	10	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
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28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(153,433)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,097	\$ 2,097	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	47	47	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	20	20	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	207	207	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,016	1,016	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	379	379	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,269	1,269	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	156	156	10
11	V	17 Administrative	137,000	Petersen Health Care, Inc.	100.00%	51,008	(85,992)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,941	2,941	12
13	V							13
14	Total		\$ 137,000			\$ 59,140	\$ * (77,860)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 820	\$	820	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	21,386		21,386	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	218		218	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	67		67	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,054		1,054	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	437		437	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,740		5,740	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,729		1,729	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,659		2,659	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	266		266	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	254		254	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		\$			\$ 34,630	\$ *	34,630	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,175	1,175	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	819	819	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	852	852	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,840	1,840	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	211	211	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,525	2,525	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	731	731	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	13,285	13,285	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 21,438	\$ *	21,438	39

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Ce # 0047530 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	157,749	0.47	0.78	Salary	\$ 1,364	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,364		13

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

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

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	11,993	\$ 2,097	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	11,993	47	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	11,993	20	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	11,993	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	11,993	207	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	11,993	1,016	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	11,993	379	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	11,993	1,269	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	11,993	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	11,993	156	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	11,993	51,008	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	11,993	2,941	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	11,993	820	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	11,993	21,386	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	11,993	218	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	11,993	67	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	11,993	1,054	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	11,993	437	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	11,993	5,740	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	11,993	1,729	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	11,993	2,659	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	11,993	266	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	11,993	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	11,993	254	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 93,770	25

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center # 0047530 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	399,145	21	\$	\$ 11,993	\$	1
2	2	Food	Resident Days	399,145	21		11,993		2
3	3	Housekeeping	Resident Days	399,145	21		11,993		3
4	4	Laundry	Resident Days	399,145	21		11,993		4
5	5	Utilities	Resident Days	399,145	21		11,993		5
6	6	Maintenance	Resident Days	399,145	21	39,101	11,993	1,175	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21		11,993		7
8	10	Nursing and Medical Records	Resident Days	399,145	21		11,993		8
9	12	Social Services	Resident Days	399,145	21		11,993		9
10	17	Administrative	Resident Days	399,145	21		11,993		10
11	19	Professional Services	Resident Days	399,145	21	27,247	11,993	819	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366	11,993	852	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225	11,993	1,840	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21		11,993		14
15	23	Inservice Training & Education	Resident Days	399,145	21		11,993		15
16	24	Travel and Seminar	Resident Days	399,145	21		11,993		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018	11,993	211	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21		11,993		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024	11,993	2,525	19
20	30	Depreciation	Resident Days	399,145	21	24,325	11,993	731	20
21	32	Interest	Resident Days	399,145	21	442,158	11,993	13,285	21
22	33	Real Estate Taxes	Resident Days	399,145	21		11,993		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21		11,993		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21		11,993		24
25	TOTALS					\$ 713,464	\$	\$ 21,438	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 850,000	\$ 824,890	12/31/13	Varies	\$ 42,322	1							
2												2							
3							Interest Income Offset				(4,660)	3							
4							Home Office Allocation-PHC				2,659	4							
5							Home Office Allocation-PHO				13,285	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 850,000	\$ 824,890			\$ 53,606	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 850,000	\$ 824,890			\$ 53,606	15							

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

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

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>49,223</u>	<u>2005</u>	<u>\$ 21,375</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	49,223		\$ 21,375	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	57	2005	1972	\$ 273,764	\$	25	\$ 10,951	\$ 10,951	\$ 49,278
5									
6									
7									
8									
Improvement Type**									
9	Original Land		2005	12,000		15	800	800	3,600
10	Sidewalks		2006	10,700		15	713	713	2,496
11	Sprinkler		2006	1,071		25	43	43	150
12	Tile Floor		2006	1,916		20	96	96	336
13	Gutters		2007	3,166		20	158	158	395
14	Lighting		2007	1,352		15	90	90	225
15	Sprinkler Head Installation		2009	6,913		15	230	230	230
16	Water Heater		2009	3,537		5	177	177	177
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				1,513			(1,513)	
28	Building Booked				15,041			(15,041)	
29	Building Improvement Booked				746			(746)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			394			25	25	
33	2009-Home Office Allocation-Building Improvements			5,896			141	141	
34									
35									
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

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

0047530

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 320,709	\$ 17,300		\$ 13,424	\$ (3,876)	\$ 56,887	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 110,036	\$ 14,938	\$ 16,647	\$ 1,709	7-10 yrs.	\$ 69,093	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,460	2,460			74
75	TOTALS	\$ 110,036	\$ 14,938	\$ 19,107	\$ 4,169		\$ 69,093	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)	\$ 452,120	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,531	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 293	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 125,980	85

**

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living (2005)	\$ 100,861	\$ 4,049	\$ 18,222	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 100,861	\$ 4,049	\$ 18,222	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,207 Description: See Attached Schedule 14A

(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	Facility	2006 Ford E250 Van	\$ 578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

Rock Falls Rehabilitation & Health Care Center
0047530
Period Beginning **1/1/2009**
Period End **12/31/2009**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	2,864
Dishwasher		708
Copier		3,381
Home Office Allocation		254
		<u>7,207</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number **Rock Falls Rehabilitation & Health Care Center**# **0047530**Report Period Beginning: **1/1/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (9,175)	\$ (9,175)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>15,000</u>)	129,079	129,079	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,554	39,554	6
7	Other Prepaid Expenses	7,395	7,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	24,000	24,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 190,853	\$ 190,853	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,075	21,375	13
14	Buildings, at Historical Cost	374,625	279,660	14
15	Leasehold Improvements, at Historical Cost	17,955	41,049	15
16	Equipment, at Historical Cost	110,035	110,036	16
17	Accumulated Depreciation (book methods)	(134,398)	(125,980)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Non-Care Asset-Ind. Lv. Bldg.</u>		100,861	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 412,292	\$ 427,001	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 603,145	\$ 617,854	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 167,825	\$ 167,825	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,015	18,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,347	2,347	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,000	26,000	32
33	Accrued Interest Payable	3,690	3,690	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	43,788	43,788	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 261,665	\$ 261,665	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	824,890	824,890	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	13,000	13,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 837,890	\$ 837,890	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,099,555	\$ 1,099,555	46
47	TOTAL EQUITY(page 18, line 24)	\$ (496,410)	\$ (481,701)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 603,145	\$ 617,854	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (134,510)	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(15,000)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (149,509)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(346,901)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (346,901)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (496,410)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Rock Falls Rehabilitation & Health Care Center** # **0047530** Report Period Beginning: **1/1/2009**Ending: **12/31/2009****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,542,056	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,542,056	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,544	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,544	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,660	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,660	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	316	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 316	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,552,576	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	502,325	31
32	Health Care	629,807	32
33	General Administration	603,984	33
B. Capital Expense			
34	Ownership	113,984	34
C. Ancillary Expense			
35	Special Cost Centers	18,169	35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,899,477	40
41	Income before Income Taxes (line 30 minus line 40)**	(346,901)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (346,901)	43

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

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

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

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

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

0047530

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,096	2,096	\$ 58,231	\$ 27.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,752	2,752	82,556	30.00	3
4	Licensed Practical Nurses	5,832	6,064	117,159	19.32	4
5	CNAs & Orderlies	25,861	26,727	242,447	9.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	2,060	19,233	9.34	9
10	Activity Assistants					10
11	Social Service Workers	1628	1,732	21,081	12.17	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,073	27,557	13.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,999	11,383	91,945	8.08	15
16	Dishwashers					16
17	Maintenance Workers	2,984	2,984	38,924	13.04	17
18	Housekeepers	9,407	9,776	82,507	8.44	18
19	Laundry	3,366	3,532	28,057	7.94	19
20	Administrator	2,080	2,080	65,894	31.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,440	2,594	33,184	12.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Transportation	175	175	1,579	9.02	32
33	Other(specify) Care Plan Coord.	2,009	2,009	41,200	20.51	33
34	TOTAL (lines 1 - 33)	75,554	78,037	\$ 951,554 *	\$ 12.19	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	14,550	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,150		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	166	\$ 5,771	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	166	\$ 5,771		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carolyn McBride	Administrator	0	\$ 65,894	Workers' Compensation Insurance	\$ 66,313	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	19,606	Advertising: Employee Recruitment	2,354	
				FICA Taxes	67,188	Health Care Worker Background Check		
				Employee Health Insurance	204,130	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	75	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	266	
				Employee Relations	944	Miscellaneous Dues & Subscriptions	351	
				Employee Retirement	141	IHCA Dues	1,500	
						Home Office Allocation	1,672	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 65,894			Less: Public Relations Expense	(351)	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 358,322	
Description			Amount	TOTAL (agree to Sch. V, line 20, col. 8)				
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 137,000	\$ 8,532				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 137,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SimpleLTC, Inc.	Computer Services		\$ 81				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,700				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	67
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 4,481	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 67	

* Attach copy of IMRF notifications

**See instructions.

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,481

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(9)
GoffWilson, P.A.	Legal	27
Jackson Lewis	Legal	211
Peter Gartelos	Legal	20
Misc.	Legal	18
Ginoli & Company	Accountants	1,269
Miscellaneous Vendors	Computer Services	20
Emdeon Business Services	Computer Services	9
Advanced Answers on Demand	Computer Services	1,130
Access 2 Go	Computer Services	109
Ivans	Computer Services	59
Kemper Technology	Computer Services	307
VisionShare	Computer Services	96
MediFax	Computer Services	39
LogmeIn	Computer Services	17
Charter Communications	Computer Services	1
Simple LTC	Computer Services	261
Miscellaneous Vendors	Miscellaneous	176
Total (agree to Schedule V, line 19, column 8)		<u>8,241</u>

Facility Name & ID Number Rock Falls Rehabilitation & Health Care Center# 0047530Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,952 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,208
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,544
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Rock Falls Rehabilitation & Health Care Center

0047530

Period Beginning 1/1/2009

Period End 12/31/2009

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%	Beds	%
Independent Living	4,778	28.49%	21	26.92%
Nursing Home	11,993	71.51%	57	73.08%
	<u>16,771</u>	<u>100.00%</u>	<u>78</u>	<u>100.00%</u>

Expense Offset:

	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	129,669	28.49%	36,943	Census	1
Food	94,032	28.49%	26,790	Census	2
Housekeeping	97,616	28.49%	27,811	Census	3
Laundry	39,420	28.49%	11,231	Census	4
Utilities	75,684	28.49%	21,562	Census	5
Maintenance	65,904	28.49%	18,776	Census	6
Depreciation (Building)	<u>15,041</u>	<u>26.92%</u>	<u>4,049</u>	Beds	30
Total	<u><u>517,366</u></u>		<u><u>147,162</u></u>		

Building Cost Offset:

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