



Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	<u>177</u>	Skilled (SNF)	<u>177</u>	<u>64,605</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>64,605</u>	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
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	<u>1,192</u>		<u>3,771</u>	<u>4,963</u>	8
9	SNF/PED					9
10	ICF	<u>36,103</u>	<u>2,625</u>	<u>1,161</u>	<u>39,889</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,295</u>	<u>2,625</u>	<u>4,932</u>	<u>44,852</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.42%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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 3,771

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Rock Island Nursing & Rehab Center # 0049866 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	199,534	31,171	29,061	259,766		259,766	(14,809)	244,957		1
2	Food Purchase		223,251		223,251	(15,739)	207,512	(130)	207,382		2
3	Housekeeping	165,648	46,387		212,035		212,035	(4,502)	207,533		3
4	Laundry	77,381	22,398	10,740	110,519		110,519	(509)	110,010		4
5	Heat and Other Utilities			155,368	155,368		155,368	(18,557)	136,811		5
6	Maintenance	50,738	55,659	150,948	257,345		257,345	(4,820)	252,525		6
7	Other (specify):*							1,644	1,644		7
8	<b>TOTAL General Services</b>	493,301	378,866	346,117	1,218,284	(15,739)	1,202,545	(41,683)	1,160,862		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,816,507	259,316	58,036	2,133,859		2,133,859	(35,263)	2,098,596		10
10a	Therapy	94,387		19,658	114,045		114,045	(14,270)	99,775		10a
11	Activities	92,948	14,871		107,819		107,819		107,819		11
12	Social Services	127,752		3,550	131,302		131,302		131,302		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,012	3,012		15
16	<b>TOTAL Health Care and Programs</b>	2,131,594	274,187	94,444	2,500,225		2,500,225	(46,521)	2,453,704		16
	<b>C. General Administration</b>										
17	Administrative	67,286		106,212	173,498		173,498	(24,852)	148,646		17
18	Directors Fees										18
19	Professional Services			176,061	176,061		176,061	(117,396)	58,665		19
20	Dues, Fees, Subscriptions & Promotions			47,925	47,925		47,925	(28,774)	19,151		20
21	Clerical & General Office Expenses	118,871	40,843	190,956	350,670		350,670	(86,382)	264,288		21
22	Employee Benefits & Payroll Taxes			362,811	362,811	15,739	378,550		378,550		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,402	3,402		3,402	167	3,569		24
25	Other Admin. Staff Transportation			7,525	7,525		7,525	6,283	13,808		25
26	Insurance-Prop.Liab.Malpractice			121,556	121,556		121,556	835	122,391		26
27	Other (specify):*							27,742	27,742		27
28	<b>TOTAL General Administration</b>	186,157	40,843	1,016,448	1,243,448	15,739	1,259,187	(222,377)	1,036,810		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,811,052	693,896	1,457,009	4,961,957		4,961,957	(310,582)	4,651,375		29

\*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.

## 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			104,766	104,766		104,766	157,735	262,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,643	99,643		99,643	(32,556)	67,087			32
33	Real Estate Taxes							129,125	129,125			33
34	Rent-Facility & Grounds			558,000	558,000		558,000	(184,609)	373,391			34
35	Rent-Equipment & Vehicles			3,805	3,805		3,805	6,211	10,016			35
36	Other (specify):*							32,368	32,368			36
37	<b>TOTAL Ownership</b>			766,214	766,214		766,214	108,274	874,488			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	99,646	292,513	298,453	690,612		690,612	(3,728)	686,884			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,908	96,908		96,908		96,908			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	99,646	292,513	395,361	787,520		787,520	(3,728)	783,792			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,910,698	986,409	2,618,584	6,515,691		6,515,691	(206,036)	6,309,655			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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(20,108)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	150,304	30		9
10	Interest and Other Investment Income	(20,852)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,766)	21		24
25	Fund Raising, Advertising and Promotional	(23,653)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(359)	20		28
29	Other-Attach Schedule	(15,101)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (65,665)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(140,370)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (140,370)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (206,036)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Fees	\$ (4,705)	21	1
2	Fees - Building Company	(250)	20	2
3	Office Expense - Building Co.	(514)	21	3
4	Professional Fees - Building Co.	(4,449)	19	4
5	Replacement Tax - Building Co.	(44)	21	5
6	2010 Seminar	(95)	24	6
7	Collection Fees	(156)	19	7
8	Amortization - Building Co.	(5,143)	31	8
9	PPA - Part A X-Ray, Lab, Infusions	(1,757)	39	9
10	Additional R&M	21,587	06	10
11	Capitalized R&M	(14,619)	06	11
12	COPE Dues	(4,956)	20	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>	(15,101)		49

Rock Island Nursing & Rehab Center

ID# 0049866

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(14,809)								(14,809)	1
2	Food Purchase	(130)											(130)	2
3	Housekeeping					(4,502)							(4,502)	3
4	Laundry					(509)							(509)	4
5	Heat and Other Utilities	(20,108)			1,551								(18,557)	5
6	Maintenance	6,968		(11,458)	(319)	(11)							(4,820)	6
7	Other (specify):*			615	1,029								1,644	7
8	<b>TOTAL General Services</b>	<b>(13,270)</b>		<b>(10,843)</b>	<b>(12,548)</b>	<b>(5,022)</b>							<b>(41,683)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(28,270)	4,934	(11,927)							(35,263)	10
10a	Therapy				(14,270)								(14,270)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,502	1,510								3,012	15
16	<b>TOTAL Health Care and Programs</b>			<b>(26,768)</b>	<b>(7,826)</b>	<b>(11,927)</b>							<b>(46,521)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(79,548)	54,696								(24,852)	17
18	Directors Fees													18
19	Professional Services	(4,605)	4,449	(127,228)	9,988								(117,396)	19
20	Fees, Subscriptions & Promotions	(29,218)	250	194									(28,774)	20
21	Clerical & General Office Expenses	(141,029)	558	54,044	45								(86,382)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(95)		262									167	24
25	Other Admin. Staff Transportation			6,283									6,283	25
26	Insurance-Prop.Liab.Malpractice			743	92								835	26
27	Other (specify):*			16,239	11,503								27,742	27
28	<b>TOTAL General Administration</b>	<b>(174,947)</b>	<b>5,257</b>	<b>(129,011)</b>	<b>76,324</b>								<b>(222,377)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(188,217)</b>	<b>5,257</b>	<b>(166,622)</b>	<b>55,950</b>	<b>(16,949)</b>							<b>(310,582)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	150,304			7,431								157,735	30
31	Amortization of Pre-Op. & Org.	(5,143)	5,143											31
32	Interest	(20,852)		(16,564)	4,860								(32,556)	32
33	Real Estate Taxes		124,475		4,650								129,125	33
34	Rent-Facility & Grounds		(184,609)										(184,609)	34
35	Rent-Equipment & Vehicles			6,211									6,211	35
36	Other (specify):*		32,368										32,368	36
37	<b>TOTAL Ownership</b>	<b>124,309</b>	<b>(22,623)</b>	<b>(10,353)</b>	<b>16,941</b>								<b>108,274</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,757)				(1,971)							(3,728)	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>(1,757)</b>				<b>(1,971)</b>							<b>(3,728)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(65,665)</b>	<b>(17,366)</b>	<b>(176,975)</b>	<b>72,891</b>	<b>(18,920)</b>							<b>(206,036)</b>	<b>45</b>

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 558,000	Rock Island Real Estate, LLC	100.00%	\$	\$ (558,000)	1
2	V	32 Interest Income		Rock Island Real Estate, LLC	100.00%			2
3	V	31 Amortization Expense		Rock Island Real Estate, LLC	100.00%	5,143	5,143	3
4	V	20 Fees		Rock Island Real Estate, LLC	100.00%	250	250	4
5	V	36 Insurance		Rock Island Real Estate, LLC	100.00%	32,368	32,368	5
6	V	32 Interest Expense		Rock Island Real Estate, LLC	100.00%			6
7	V	21 Office		Rock Island Real Estate, LLC	100.00%	514	514	7
8	V	19 Professional Fees		Rock Island Real Estate, LLC	100.00%	4,449	4,449	8
9	V	33 Real Estate Taxes		Rock Island Real Estate, LLC	100.00%	124,475	124,475	9
10	V	34 Rent-Base		Rock Island Real Estate, LLC	100.00%	350,342	350,342	10
11	V	34 Rent-Escrow		Rock Island Real Estate, LLC	100.00%	23,049	23,049	11
12	V	21 Replacement Tax		Rock Island Real Estate, LLC	100.00%	44	44	12
13	V							13
14	Total		\$ 558,000			\$ 540,634	\$ * (17,366)	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	6 REPAIRS AND MAINT.	\$ 19,116	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,658	\$ (11,458)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	615	615
17	V	10 NURSING	38,232	S.I.R. MANAGEMENT, INC.	100.00%	9,962	(28,270)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,502	1,502
19	V	19 PROFESSIONAL FEES	129,444	S.I.R. MANAGEMENT, INC.	100.00%	1,667	(127,777)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	194	194
21	V	21 CLERICAL & GENERAL	38,232	S.I.R. MANAGEMENT, INC.	100.00%	22,823	(15,409)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	262	262
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,283	6,283
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	743	743
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,922	2,922
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(16,564)	(16,564)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,211	6,211
28	V						
29	V	17 ADMINISTRATIVE	96,648	S.I.R. MANAGEMENT, INC.	100.00%	17,100	(79,548)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	549	549
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	69,453	69,453
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,317	13,317
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 321,672			\$ 144,697	\$ * (176,975)

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

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/09Ending: 12/31/09

## 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%	\$ 4,307	\$ (14,809)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	665	665	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	4,934	4,934	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	750	750	18
19	V	17	ADMIN./LEGAL SALARIES	9,564	S.I.R. MANAGEMENT, INC.	100.00%	64,260	54,696	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	9,950	9,950	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,503	11,503	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	19,116	S.I.R. MANAGEMENT, INC.	100.00%	4,846	(14,270)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	760	760	25
26	V								26
27	V	6	MAINTENANCE SALARIES	2,760	S.I.R. MANAGEMENT, INC.	100.00%	1,997	(763)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	364	364	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,551	1,551	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	444	444	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	38	38	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	45	45	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	92	92	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	7,431	7,431	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,860	4,860	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,650	4,650	37
38	V								38
39	Total		\$ 50,556				\$ 123,447	\$ * 72,891	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	<u>1 Dietary</u>	\$	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	\$		15
16	V	<u>3 Housekeeping</u>	<u>49,026</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>44,524</u>	<u>(4,502)</u>	16
17	V	<u>4 Laundry</u>	<u>5,540</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>5,031</u>	<u>(509)</u>	17
18	V	<u>6 Repairs &amp; Maintenance</u>	<u>119</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>108</u>	<u>(11)</u>	18
19	V	<u>10 Nursing</u>	<u>129,883</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>117,956</u>	<u>(11,927)</u>	19
20	V	<u>11 Activities</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			20
21	V	<u>12 Social Service</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			21
22	V	<u>20 Dues, Fees And Subscriptions</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			22
23	V	<u>21 Office And Clerical</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			23
24	V	<u>22 Employee Benefits</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			24
25	V	<u>24 Seminars &amp; Education</u>		<u>Xcel Supply, LLC</u>	<u>100.00%</u>			25
26	V	<u>39 Ancillary</u>	<u>21,462</u>	<u>Xcel Supply, LLC</u>	<u>100.00%</u>	<u>19,491</u>	<u>(1,971)</u>	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	<b>Total</b>		<b>\$ 206,030</b>			<b>\$ 187,110</b>	<b>\$ * (18,920)</b>	<b>39</b>

\* 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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: 01/01/09 Ending: 12/31/09

## 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	Eric Rothner	Relative	Administrative	N/A	See Attached	0.39	0.84%	Alloc. Salary	\$ 5,564	17-7	1
2	Bryan Barrish	Relative	Administrative	N/A	See Attached	1.67	4.18%	Alloc. Salary	10,849	17-7	2
3	Michael Giannini	Relative	Administrative	N/A	See Attached	1.95	4.88%	Alloc. Salary	9,287	17-7	3
4	Sarah Barrish	Relative	Administrative	N/A	See Attached	2.23	5.58%	Alloc. Salary	5,673	17-7	4
5	Kirsten Barrish	Relative	Clerical	N/A	See Attached	0.95	5.59%	Alloc. Salary	752	21-7	5
6	Nineta Guzman	Relative	Dietary	1.13%	See Attached	2.78	5.56%	Alloc. Salary	4,307	1-7	6
7	Louise Bergthold	Member	Administrative	1.13%	See Attached	3.06	5.56%	Alloc. Salary	10,849	17-7	7
8	Tom Winter	Member	Administrative	5.65%	See Attached	2.53	4.22%	Alloc. Salary	10,392	17-7	8
9	Jeff Oravec	Member	Administrative	1.13%	See Attached	2.13	5.33%	Alloc. Salary	6,709	17-7	9
10	Patricia McDiarmid	Member	Administrative	1.13%	See Attached	2.78	5.56%	Alloc. Salary	6,720	17-7	10
11	Fay Chin	Member	Nursing	1.13%	See Attached	2.23	5.58%	Alloc. Salary	4,934	10-7	11
12	Andres Chin	Relative	Clerical	1.13%	See Attached	2.13	5.33%	Alloc. Salary	3,668	21-7	12
13								TOTAL	\$ 79,704		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:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	44,852	\$ 7,658	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		44,852	615	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	44,852	9,962	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		44,852	1,502	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	44,852	1,667	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		44,852	194	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	44,852	22,823	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		44,852	262	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		44,852	6,283	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		44,852	743	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		44,852	2,922	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		44,852	(16,564)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		44,852	6,211	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	44,852	17,100	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		44,852	549	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	44,852	69,453	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		44,852	13,317	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 144,697	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	806,183	12	\$ 77,418	\$ 77,418	44,852	\$ 4,307	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		44,852	665	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	44,852	4,934	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		44,852	750	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	44,852	64,260	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		44,852	9,950	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		44,852	11,503	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	19,116	4,846	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		19,116	760	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	2,898	1,997	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		2,898	364	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		707	1,551	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		707	444	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		707	38	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		707	45	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		707	92	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		707	7,431	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		707	4,860	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		707	4,650	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 123,447	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

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					44,524	2
3	4	Laundry	Direct Allocation					5,031	3
4	6	Repairs & Maintenance	Direct Allocation					108	4
5	10	Nursing	Direct Allocation					117,956	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					19,491	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				\$	\$		\$ 187,110	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rock Island Nursing & Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$			\$	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				1,100,000			99,643	6						
7	Shareholder Loan		X					900,000				7						
8	See Supplemental Schedule										(11,704)	8						
9	<b>TOTAL Facility Related</b>						\$	\$ 2,000,000			\$ 87,939	9						
	<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(20,852)	10						
11												11						
12												12						
13	See Supplemental Schedule											13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (20,852)	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,000,000			\$ 67,087	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,368 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:

01/01/09

Ending:

12/31/09

**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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<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			\$	\$			\$ (11,704)	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.)

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:

01/01/09 Ending:

12/31/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>224,770</u>	<u>1997</u>	<u>\$ 420,000</u>	<u>1</u>
2					<u>2</u>
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:

**01/01/09**

Ending:

**12/31/09**

**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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2002		10,887		20	396	396	2,799	9
10	Various		2003		5,954		20	216	216	1,317	10
11	Various		2004		9,240		20	336	336	1,862	11
12	Various		2005		48,760		20	2,139	2,139	9,538	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

**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		3,636,437			95,830	95,830	1,162,065	67
68		80,687	3,613		2,840	(773)	28,910	68
69			101,152			(101,152)		69
70		\$ 3,791,965	\$ 104,765		\$ 101,757	\$ (3,008)	\$ 1,206,491	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rock Island Nursing &amp; Rehab Center

# 0049866

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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 12A, Carried Forward</b>		\$ 3,791,965	\$ 104,765		\$ 101,757	\$ (3,008)	\$ 1,206,491	1
2	Roof/Ac Compressor/Linen Chute Discharge Door	2006	12,843		20	467	467	1,849	2
3	Elevator Fire Service/Door Keypads	2006	26,225		20	954	954	3,510	3
4	Water Heater	2008	6,570		20	1,314	1,314	2,519	4
5	Nurse Station	2008	19,200		20	1,920	1,920	2,720	5
6	Floor Work	2008	75,693		20	7,569	7,569	10,723	6
7	Ceiling Tile	2008	35,437		20	3,544	3,544	6,201	7
8	Draperies	2008	42,557		20	8,511	8,511	11,349	8
9	Painting	2008	226,884		20	22,688	22,688	30,251	9
10	Doors	2008	3,291		20	329	329	357	10
11	Compressor	2008	5,717		20	1,143	1,143	1,620	11
12	Handrails	2008	156,327		20	15,633	15,633	19,541	12
13	Flooring	2008	57,770		20	2,556	2,556	2,556	13
14	A/C Units	2008	4,386		20	219	219	329	14
15	Heat / Cool Units	2008	2,632		20	132	132	175	15
16	Signage	2009	3,992		20	399	399	399	16
17	Bath/Shower Room	2009	4,175		20	191	191	191	17
18	Flooring	2009	20,323		20	931	931	931	18
19	Beauty Shop - Flooring, Wood Blinds, Furnishings	2009	11,709		20	1,073	1,073	1,073	19
20	Beauty Shop/Office - Construction, Wall Work, Paint	2009	12,195		20	559	559	559	20
21	Firestopping	2009	28,918		20	1,205	1,205	1,205	21
22	Flooring	2009	3,205		20	134	134	134	22
23	Baseboard	2009	8,633		20	324	324	324	23
24	Generator	2009	64,744		20	2,158	2,158	2,158	24
25	Exterior Sign	2009	10,344		20	345	345	345	25
26	Generator Panel	2009	4,320		20	144	144	144	26
27	Emergency Panel	2009	7,465		20	218	218	218	27
28	Wiring Recepticles	2009	5,654		20	165	165	165	28
29	Light Fixtures	2009	2,914		20	121	121	121	29
30	Elevator	2009	15,382		20	256	256	256	30
31	Elevator	2009	15,382		20	256	256	256	31
32	Doors	2009	3,108		20	104	104	104	32
33	Doors & Hardware	2009	8,587		20	286	286	286	33
34	TOTAL (lines 1 thru 33)		\$ 4,698,547	\$ 104,765		\$ 177,605	\$ 72,840	\$ 1,309,060	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,698,547	\$ 104,765		\$ 177,605	\$ 72,840	\$ 1,309,060	1
2	2009	7,225		20	241	241	241	2
3	2009	3,186		20	80	80	80	3
4	2009	2,630		20	66	66	66	4
5	2009	5,092		20	127	127	127	5
6	2009	5,032		20	105	105	105	6
7	2009	4,915		20	82	82	82	7
8	2009	6,395		20	80	80	80	8
9	2009	3,474		20	29	29	29	9
10	2009	5,475		20	274	274	274	10
11	2009	3,995		20	200	200	200	11
12	2009	2,501		20	125	125	125	12
13	2009	2,649		20	265	265	265	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		\$ 4,751,116	\$ 104,765		\$ 179,278	\$ 74,513	\$ 1,310,733	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:

01/01/09

Ending:

12/31/09

**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
1		\$ 4,751,116	\$ 104,765		\$ 179,278	\$ 74,513	\$ 1,310,733
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 4,751,116	\$ 104,765		\$ 179,278	\$ 74,513	\$ 1,310,733

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:

01/01/09

Ending:

12/31/09

**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	
1		\$ 4,751,116	\$ 104,765		\$ 179,278	\$ 74,513	\$ 1,310,733	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	TOTAL (lines 1 thru 33)	\$ 4,751,116	\$ 104,765		\$ 179,278	\$ 74,513	\$ 1,310,733	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 <b>Building Company Information</b>								1
2 <b>Buildings:</b>								2
3	1975	3,579,244		39	92,208	92,208	1,133,433	3
4								4
5								5
6								6
7								7
8 <b>Leasehold Improvements:</b>								8
9 <b>Flooring, Wallcovering, Window Treatment, Doors</b>	1997	50,964		20	3,310	3,310	26,297	9
10 <b>Windows</b>	1998	2,278		20	114	114	835	10
11 <b>Walk in Freezer Compressor</b>	2000	2,097		20	105	105	838	11
12 <b>Electrical Work</b>	2001	1,854		20	93	93	662	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

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:

**01/01/09**

Ending:

**12/31/09**

**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	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>	\$	\$		\$	\$	\$	34
			<b>3,636,437</b>		<b>95,830</b>	<b>95,830</b>	<b>1,162,065</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:

01/01/09

Ending:

12/31/09**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>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>Buildings:</b>								3
4	Allocate From SIR Properties - SIR Mgmt	1993	24,849	789	35	710	(79)	11,714	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocate From SIR - Management	1993	6,300	175	20	312	137	5,310	9
10	Allocate From SIR - Management	1994	20		20			20	10
11	Allocate From SIR - Management	1995	144		20	7	7	104	11
12	Allocate From SIR - Management	1997	9,681	217	20	484	267	6,200	12
13	Allocate From SIR - Management	1999	761		20	38	38	390	13
14	Allocate From SIR - Management	1999			20				14
15	Allocate From SIR - Management	2000	899		20	45	45	429	15
16	Allocate From SIR - Management	2007	2,888	515	20	144	(371)	317	16
17	Allocate From SIR - Management	2008	7,958	796	20	502	(294)	925	17
18	Allocate From SIR - Management	2009	19,774	40	20	242	202	242	18
19									19
20	Allocated From SIR Properties - SIR Mgmt	2009	1,492	853	20	60	(793)	60	20
21	Allocated From SIR Properties - SIR Mgmt	2007	435	63	20	22	(41)	65	21
22	Allocated From SIR Properties - SIR Mgmt	2002	98		20	5	5	37	22
23	Allocated From SIR Properties - SIR Mgmt	1999	3,149	157	20	157		1,653	23
24	Allocated From SIR Properties - SIR Mgmt	1998	1,505		20	75	75	865	24
25	Allocated From SIR Properties - SIR Mgmt	1997	94		20	5	5	63	25
26	Allocated From SIR Properties - SIR Mgmt	1994	237	6	20	12	6	183	26
27	Allocated From SIR Properties - SIR Mgmt	1993	403	2	20	20	18	333	27
28									28
29									29
30									30
31									31
32									32
33									33
34									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:

01/01/09

Ending:

12/31/09

**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		
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								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 80,687	\$ 3,613		\$ 2,840	\$ (773)	\$ 28,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 552,097	\$ 3,702	\$ 75,825	\$ 72,123	10	\$ 306,735	71
72	Current Year Purchases	55,567	117	3,586	3,469	10	3,586	72
73	Fully Depreciated Assets	20,799		198	198	10	20,799	73
74								74
75	TOTALS	\$ 628,463	\$ 3,819	\$ 79,609	\$ 75,790		\$ 331,120	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)	\$ 5,799,579	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,584	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 258,888	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 150,304	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,641,854	85

\*\*

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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		\$ 373,391			3
4	Additions							4
5								5
6								6
7	TOTAL		177		\$ 373,391			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: \$ 10,016 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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		Contract	Total
		1 Drop-outs	2 Completed		
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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	133,833	\$					\$	133,833	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						16,039							16,039	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs						148,581							148,581	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 prescrpts							169,281						169,281	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify): <b>See Supplemental</b>				99,646					123,232						222,878	13
14	<b>TOTAL</b>				\$ 99,646				\$ 298,453	\$ 292,513					\$ 690,612		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**# **0049866**Report Period Beginning: **01/01/09**

Ending:

**12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(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	\$ 18,366	\$ 47,100	1
2	Cash-Patient Deposits	67,544	67,544	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,394,266	1,394,266	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		1,180,000	5
6	Prepaid Insurance	26,551	32,287	6
7	Other Prepaid Expenses	747	747	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,507,474	\$ 2,721,944	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	834,029	834,029	15
16	Equipment, at Historical Cost	432,404	432,404	16
17	Accumulated Depreciation (book methods)	(144,238)	(144,238)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,524)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	4,425	4,425	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,126,620	\$ 1,140,815	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,634,094	\$ 3,862,759	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 270,159	\$ 270,159	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,064	69,064	28
29	Short-Term Notes Payable	2,000,000	2,000,000	29
30	Accrued Salaries Payable	103,324	103,324	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,489	18,489	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	<a href="#">See Attached Schedule</a>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,461,036	\$ 2,461,036	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	<a href="#">See Attached Schedule</a>			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>	\$ 2,461,036	\$ 2,461,036	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 173,058	\$ 1,401,723	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,634,094	\$ 3,862,759	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>272,232</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>272,232</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(99,174)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(99,174)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>173,058</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rock Island Nursing & Rehab Center**# **0049866**Report Period Beginning: **01/01/09**Ending: **12/31/09**

**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	\$ 6,090,615	1
2	Discounts and Allowances for all Levels	(642,637)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,447,978</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	683,569	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 683,569</b>	<b>8</b>
<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	165,812	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,423	19
20	Radiology and X-Ray	1,420	20
21	Other Medical Services	75,463	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 264,118</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	20,852	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 20,852</b>	<b>26</b>
<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>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,416,517</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,218,284	31
32	Health Care	2,500,225	32
33	General Administration	1,243,448	33
<b>B. Capital Expense</b>			
34	Ownership	766,214	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	690,612	35
36	Provider Participation Fee	96,908	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,515,691</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(99,174)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (99,174)</b>	<b>43</b>

\* 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: **01/01/09**

Ending:

**12/31/09**

**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	1,981	2,086	\$ 57,926	\$ 27.77	1
2	Assistant Director of Nursing	2,021	2,166	50,881	23.49	2
3	Registered Nurses	6,374	6,710	144,462	21.53	3
4	Licensed Practical Nurses	36,329	38,779	705,241	18.19	4
5	CNAs & Orderlies	73,777	73,837	758,290	10.27	5
6	CNA Trainees					6
7	Licensed Therapist	3,983	4,007	99,646	24.87	7
8	Rehab/Therapy Aides	6,442	6,920	94,387	13.64	8
9	Activity Director	1,989	2,078	29,691	14.29	9
10	Activity Assistants	6,077	6,448	63,257	9.81	10
11	Social Service Workers	9,685	10,303	127,752	12.40	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,086	39,006	18.70	13
14	Head Cook	8,582	9,273	87,100	9.39	14
15	Cook Helpers/Assistants	9,198	9,243	73,428	7.94	15
16	Dishwashers					16
17	Maintenance Workers	3,872	4,093	50,738	12.40	17
18	Housekeepers	17,817	18,806	165,648	8.81	18
19	Laundry	8,311	8,978	77,381	8.62	19
20	Administrator	2,021	2,086	67,286	32.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,042	8,388	118,871	14.17	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	4,390	4,703	71,961	15.30	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,202	2,324	27,746	11.94	33
34	TOTAL (lines 1 - 33)	215,130	223,314	\$ 2,910,698 *	\$ 13.03	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	\$ 9,945	01-03	35
36	Medical Director	Monthly	13,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	38,232	10-03	38
39	Pharmacist Consultant	Monthly	688	10-03	39
40	Physical Therapy Consultant	195	11,682	10a-03	40
41	Occupational Therapy Consultant	121	7,249	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	727	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	66	3,550	12-03	45
46	Other(specify)				46
47	<u>Specialized Services</u>	Monthly	19,116	10-03	47
48	<u>Dir. Of Food Service</u>	Monthly	19,116	01-03	48
49	TOTAL (lines 35 - 48)	394	\$ 123,505		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



**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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nursing & Rehab Center# 0049866Report Period Beginning: 01/01/09Ending: 12/31/09**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. II Council on LTC - \$12,209
- (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. \$ 1,039 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 X NO        If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
River Park Healthcare Center #0042549
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 96,908  
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. \$ 15,739 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
- (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.