

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

<p>I. IDPH License ID Number: <u>0050617</u></p> <p>Facility Name: <u>Rochelle Gardens Care Center</u></p> <p>Address: <u>1021 Caron Road</u> <u>Rochelle</u> <u>61068</u> Number City Zip Code</p> <p>County: <u>Ogle</u></p> <p>Telephone Number: <u>(815) 562-4047</u> Fax # <u>(815) 562-6689</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/31/2006</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 689-5869</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2010</u> to <u>12/31/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Telephone) <u>()</u> Fax # <u>()</u>																																				

Facility Name & ID Number Rochelle Gardens Care Center

0050617 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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	5,132	4,843		9,975	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,132	4,843		9,975	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 36.93%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/31/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/31/2006 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Rochelle Gardens Care Center # 0050617 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	93,792	8,603		102,395		102,395	1,858	104,253		1
2	Food Purchase		58,955		58,955		58,955	(2,287)	56,668		2
3	Housekeeping	61,402	10,653		72,055		72,055	22	72,077		3
4	Laundry	30,159	3,773		33,932		33,932		33,932		4
5	Heat and Other Utilities			57,206	57,206		57,206	185	57,391		5
6	Maintenance	35,886	11,787	15,371	63,044		63,044	1,081	64,125		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							435	435		7
8	TOTAL General Services	221,239	93,771	72,577	387,587		387,587	1,294	388,881		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	598,922	23,965	10,050	632,937		632,937	28	632,965		10
10a	Therapy		69	348	417		417		417		10a
11	Activities	24,217	120	149	24,486		24,486	(343)	24,143		11
12	Social Services	33,168	17		33,185		33,185		33,185		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	TOTAL Health Care and Programs	656,307	24,171	22,547	703,025		703,025	(315)	702,710		16
	C. General Administration										
17	Administrative			97,000	97,000		97,000	(37,023)	59,977		17
18	Directors Fees										18
19	Professional Services			4,619	4,619		4,619	2,617	7,236		19
20	Dues, Fees, Subscriptions & Promotions			3,818	3,818		3,818	666	4,484		20
21	Clerical & General Office Expenses	18,032	2,939	9,022	29,993		29,993	18,716	48,709		21
22	Employee Benefits & Payroll Taxes			137,733	137,733		137,733	1,776	139,509		22
23	Inservice Training & Education							133	133		23
24	Travel and Seminar							15	15		24
25	Other Admin. Staff Transportation			3,480	3,480		3,480	1,664	5,144		25
26	Insurance-Prop.Liab.Malpractice			34,765	34,765		34,765	276	35,041		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,546	7,546		27
28	TOTAL General Administration	18,032	2,939	290,437	311,408		311,408	(3,614)	307,794		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	895,578	120,881	385,561	1,402,020		1,402,020	(2,635)	1,399,385		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 Rochelle Gardens Care Center

#0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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			106,543	106,543		106,543	(19,891)	86,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,839	6,839		6,839	11,334	18,173			32
33	Real Estate Taxes			8,054	8,054		8,054	(1,321)	6,733			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,316	1,316		1,316	255	1,571			35
36	Other (specify):*											36
37	TOTAL Ownership			122,752	122,752		122,752	(9,623)	113,129			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			40,515	40,515		40,515		40,515			42
43	Other (specify):* Non-allowable Cost		415	13,470	13,885		13,885	(13,885)				43
44	TOTAL Special Cost Centers		415	53,985	54,400		54,400	(13,885)	40,515			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	895,578	121,296	562,298	1,579,172		1,579,172	(26,143)	1,553,029			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,287)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,520)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,031)	30		9
10	Interest and Other Investment Income	(435)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(4,722)	43		24
25	Fund Raising, Advertising and Promotional	(1,252)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(3,419)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,816)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	14,673	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 14,673		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (26,143)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Rochelle Gardens Care Center

ID# 0050617

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Chamber of Commerce Dues	(250)	20	1
2	Resident Flowers	(33)	43	2
3	Disallowed Special Events	(494)	43	3
4	Offset Transportation Revenue	(343)	11	4
5	Labs	(714)	43	5
6	Disallow Real Estate Tax penalty	(1,585)	33	6
7				7
8				8
9				9
10				10
11				11
12				12
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,419)		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 B. 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%	\$ 1,858	\$ 1,858	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	185	185	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,081	1,081	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	435	435	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	28	28	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	97,000	Petersen Health Care, Inc.	100.00%	59,977	(37,023)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,059	2,059	12
13	V							13
14	Total		\$ 97,000			\$ 65,645	\$ * (31,355)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 510	\$	510	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,493		18,493	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	133		133	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	15		15	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,664		1,664	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	276		276	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,546		7,546	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,140		2,140	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,467		2,467	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	264		264	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	255		255	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		\$			\$ 33,763	\$ *	33,763	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 Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Network, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	558	558	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	406	406	27	
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	223	223	28	
29	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	1,776	1,776	29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	9,302	9,302	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 12,265	\$ *	12,265	39

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

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	180,983	0.38	0.63	Salary	\$ 1,267	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,267		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 Rochelle Gardens Care Center# 0050617

Report Period Beginning:

1/1/2010Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	9,975	\$ 1,858	1
2	2	Food	Resident Days	1,527,029	77	0	0	9,975	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	9,975	22	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	9,975	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	9,975	185	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	9,975	1,081	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	9,975	435	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	9,975	28	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	9,975	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	9,975	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	9,975	59,977	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	9,975	2,059	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	9,975	510	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	9,975	18,493	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	9,975	133	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	9,975	15	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	9,975	1,664	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	9,975	276	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	9,975	7,546	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	9,975	2,140	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	9,975	2,467	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	9,975	264	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	9,975	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	9,975	255	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 99,408	25

Facility Name & ID Number Rochelle Gardens Care Center# 0050617

Report Period Beginning:

1/1/2010Ending: 2/31/2010

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 Network, 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	196,542	12	\$	\$	9,975	\$	1
2	2	Food	Resident Days	196,542	12			9,975		2
3	3	Housekeeping	Resident Days	196,542	12			9,975		3
4	4	Laundry	Resident Days	196,542	12			9,975		4
5	5	Utilities	Resident Days	196,542	12			9,975		5
6	6	Maintenance	Resident Days	196,542	12			9,975		6
7	7	Mgmt. Allocation of Benefits	Resident Days	196,542	12			9,975		7
8	10	Nursing and Medical Records	Resident Days	196,542	12			9,975		8
9	10A	Therapy	Resident Days	196,542	12			9,975		9
10	15	Mgmt. Allocation of Benefits	Resident Days	196,542	12			9,975		10
11	17	Administrative	Resident Days	196,542	12			9,975		11
12	19	Professional Services	Resident Days	196,542	12	10,985		9,975	558	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	196,542	12	8,001		9,975	406	13
14	21	Clerical and General Office	Resident Days	196,542	12	4,389		9,975	223	14
15	22	Employee Benefits & Payroll	Resident Days	196,542	12	35,000		9,975	1,776	15
16	24	Travel and Seminar	Resident Days	196,542	12			9,975		16
17	25	Other Admin. Staff Transport.	Resident Days	196,542	12			9,975		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	196,542	12			9,975		18
19	27	Mgmt. Allocation of Benefits	Resident Days	196,542	12			9,975		19
20	30	Depreciation	Resident Days	196,542	12			9,975		20
21	32	Interest	Resident Days	196,542	12	183,276		9,975	9,302	21
22	33	Real Estate Taxes	Resident Days	196,542	12			9,975		22
23	34	Rent-Facility and Grounds	Resident Days	196,542	12			9,975		23
24	35	Rent-Equipment & Vehicles	Resident Days	196,542	12			9,975		24
25	TOTALS					\$ 241,651	\$		\$ 12,265	25

Facility Name & ID Number

Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	The Private Bank		X	Mortgage	Varies	11/1/09	100,304	\$ 98,454	12/31/14	Varies	\$ 6,839	1							
2												2							
3							Interest Income Offset				(435)	3							
4							Home Office Allocation-PHC				2,467	4							
5							Home Office Allocation-PHN				9,302	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 100,304	\$ 98,454			\$ 18,173	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 100,304	\$ 98,454			\$ 18,173	15							

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	54,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	\$	30,009	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(24,491)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,960	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	264	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	6,733	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005		8	
	2006	34,717	9	
	2007	35,073	10	
	2008	52,826	11	
	2009	30,009	12	
Accrual based on prior year tax bill.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,863 B. General Construction Type: Exterior Brick Frame Concrete Block 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>105,000</u>	<u>2006</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	105,000		\$ 60,000	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	74	2006		\$ 1,532,000	\$	30	\$ 51,067	\$ 51,067	\$ 229,801	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Fire System	2006		2,215		15	148	148	666	9
10	Exterior Sign	2007		4,130		15	275	275	963	10
11	Draperies	2007		2,537		10	254	254	889	11
12	Painting of Dining Room, Entry Halls, Office Walls, Ceilings	2007		1,225		15	82	82	287	12
13	Landscaping	2007		518		15	35	35	122	13
14	Painting of Resident Rooms, Bathrooms, Hallways, and Doors	2007		5,700		15	380	380	1,330	14
15	Painting of C-Wing	2007		2,930		15	195	195	683	15
16	Carpet for Resident Rooms	2007		21,701		15	1,447	1,447	5,064	16
17	Installation of Tile in Main Hall	2007		6,876		15	458	458	1,603	17
18	Wallpaper for Central Area of Nursing Home	2007		1,985		15	132	132	463	18
19	Landscaping	2007		3,852		15	257	257	899	19
20	Sprinkler Installation	2009		10,994		15	732	732	1,098	20
21	Smoke Detectors Replacement	2010		5,325		10	266	266	266	21
22	Sprinkler System Repair	2010		9,787		10	489	489	489	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				34			(34)		30
31	Building Booked				61,280			(61,280)		31
32	Building Improvement Booked				4,182			(4,182)		32
33										33
34	2010-Home Office Allocation-Building Improvements			4,795			115	115		34
35	2010-Home Office Allocation-Land Improvements			448			25	25		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

Facility Name & ID Number **Rochelle Gardens Care Center**

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,617,018		65,496	56,357	(9,139)	244,623

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

Facility Name & ID Number Rochelle Gardens Care Center

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$ 280,499	\$ 40,434	\$ 28,050	\$ (12,384)	10 yrs.	\$ 125,533	71
72	Current Year Purchases	4,903	613	245	(368)	10 yrs.	245	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,000	2,000			74
75	TOTALS	\$ 285,402	\$ 41,047	\$ 30,295	\$ (10,752)		\$ 125,778	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,962,420	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,543	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,652	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,891)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 370,401	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: 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: \$ 1,571 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			\$ _____	\$ _____	17
18			<u>N/A</u>		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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

Rochelle Gardens Care Center

0050617

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	32
Dishwasher		708
Copier		576
Home Office Allocation		255
		<u>1,571</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	10A(3)	hrs		23	348		23	348	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				69		69	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			\$	23	\$ 348	\$ 69	23	\$ 417	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 Rochelle Gardens Care Center# 0050617Report Period Beginning: 1/1/2010Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 800	\$ 800	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	13,849	13,849	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,338	22,338	6
7	Other Prepaid Expenses	5,883	5,883	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from prior owner</u>	6,292	6,292	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 49,162	\$ 49,162	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,518	60,000	13
14	Buildings, at Historical Cost	1,532,000	1,536,795	14
15	Leasehold Improvements, at Historical Cost	76,720	80,223	15
16	Equipment, at Historical Cost	287,939	285,402	16
17	Accumulated Depreciation (book methods)	(436,104)	(370,401)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,521,073	\$ 1,592,019	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,570,235	\$ 1,641,181	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,840,161	\$ 1,840,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,690	49,690	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,245	11,245	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,960	30,960	32
33	Accrued Interest Payable	626	626	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	12,727	12,727	36
37	<u>Accrued Management fees</u>	4,500	4,500	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,949,909	\$ 1,949,909	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	98,454	98,454	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 98,454	\$ 98,454	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,048,363	\$ 2,048,363	46
47	TOTAL EQUITY(page 18, line 24)	\$ (478,128)	\$ (407,182)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,570,235	\$ 1,641,181	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,788)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(27,043)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (33,831)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(444,297)	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)	\$ (444,297)	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)	\$ (478,128)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rochelle Gardens Care Center# 0050617Report Period Beginning: 1/1/2010Ending: 12/31/2010**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	\$ 1,131,810	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,131,810	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	2,287	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)	\$ 2,287	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	435	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 435	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	343	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 343	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,134,875	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	387,587	31
32	Health Care	703,025	32
33	General Administration	311,408	33
B. Capital Expense			
34	Ownership	122,752	34
C. Ancillary Expense			
35	Special Cost Centers	13,885	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,579,172	40
41	Income before Income Taxes (line 30 minus line 40)**	(444,297)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (444,297)	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 **Rochelle Gardens Care Center**

0050617

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	1,907	1,971	\$ 59,989	\$ 30.44	1
2	Assistant Director of Nursing	863	887	19,995	22.54	2
3	Registered Nurses	3,536	3,552	90,248	25.41	3
4	Licensed Practical Nurses	6,791	6,925	144,424	20.86	4
5	CNAs & Orderlies	22,650	22,731	284,266	12.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,136	1,136	12,544	11.04	9
10	Activity Assistants	569	569	7,237	12.72	10
11	Social Service Workers	1,860	1,876	33,168	17.68	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,212	11.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,736	7,908	69,580	8.80	15
16	Dishwashers					16
17	Maintenance Workers	1,935	2,111	35,886	17.00	17
18	Housekeepers	6,485	6,844	61,402	8.97	18
19	Laundry	3,482	3,612	30,159	8.35	19
20	Administrator	2,080	2,080	58,710	28.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,068	1,153	18,032	15.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	493	493	4,436	9.00	33
34	TOTAL (lines 1 - 33)	64,671	65,928	\$ 954,288 *	\$ 14.47	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	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,574	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)		\$ 13,574		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	106	\$ 3,711	10(3)	50
51	Licensed Practical Nurses	136	4,765	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	242	\$ 8,476		53

Rochelle Gardens Care Center

Period Beginning **1/1/2010**
Period End **12/31/2010**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator				#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation				#DIV/0!
Marketing				#DIV/0!
TOTAL				

Rochelle Gardens Care Center

0050617

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,619

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	2
Healthcare Resources International	Legal	25
Ginoli & Company	Accountants	922
Bank of America	Accountants	80
Miscellaneous Vendors	Computer Services	12
VisionShare	Computer Services	110
Advanced Answers on Demand	Computer Services	688
Access 2 Go	Computer Services	112
Kemper Technology	Computer Services	95
MediFax	Computer Services	39
LogmeIn	Computer Services	28
Simple LTC	Computer Services	439
Optimizer Systems	Other Professional I	16
Clifton Gunderson	Other Professional I	49
Total (agree to Schedule V, line 19, column 8)		<u>7,236</u>

Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			<u><u>-</u></u>

Facility Name & ID Number Rochelle Gardens Care Center# 0050617Report Period Beginning: 1/1/2010Ending: 12/31/2010**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. 1,000 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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,594 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,515
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? N/A 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. \$ 2,287
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 343
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
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.