FOR BHF USE

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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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0047415

Facility Name: Bloomington Rehab & HCC

Address: 1925 South Main St (Number) Bloomington (City) 61701 (Zip Code)

County: McLean

Telephone Number: (309) 829-4348 **Fax #** (309) 827-4570

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2013 to 12/31/2013 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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**

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			826	826	8
9	SNF/PED					9
10	ICF	16,789	1,728	507	19,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,789	1,728	1,333	19,850	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.72%

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 [X] NO [ ]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 826

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	90,938	12,836		103,774		103,774	3,911	107,685			1
2	Food Purchase		105,569		105,569		105,569	(318)	105,251			2
3	Housekeeping	59,835	19,014		78,849		78,849	39	78,888			3
4	Laundry	34,757	15,435		50,192		50,192		50,192			4
5	Heat and Other Utilities			59,839	59,839		59,839	297	60,136			5
6	Maintenance	39,908	9,477	14,719	64,104		64,104	1,916	66,020			6
7	Other (specify):* Home Off. Ben. All.							221	221			7
8	TOTAL General Services	225,438	162,331	74,558	462,327		462,327	6,066	468,393			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	816,352	90,599	10,771	917,722		917,722	(363)	917,359			10
10a	Therapy			248,770	248,770		248,770		248,770			10a
11	Activities	41,025	290	714	42,029		42,029	(5,985)	36,044			11
12	Social Services	8,747			8,747		8,747		8,747			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	866,124	90,889	273,255	1,230,268		1,230,268	(6,348)	1,223,920			16
	C. General Administration											
17	Administrative			246,200	246,200		246,200	(174,860)	71,340			17
18	Directors Fees											18
19	Professional Services			16,704	16,704		16,704	103,802	120,506			19
20	Dues, Fees, Subscriptions & Promotions			3,455	3,455		3,455	1,349	4,804			20
21	Clerical & General Office Expenses	38,015	3,077	35,114	76,206		76,206	51,697	127,903			21
22	Employee Benefits & Payroll Taxes			189,320	189,320		189,320	(23)	189,297			22
23	Inservice Training & Education			264	264		264	78	342			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			10,568	10,568		10,568	3,621	14,189			25
26	Insurance-Prop.Liab.Malpractice			28,881	28,881		28,881	699	29,580			26
27	Other (specify):* Home Off. Ben. All.							4,487	4,487			27
28	TOTAL General Administration	38,015	3,077	530,506	571,598		571,598	(9,146)	562,452			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,129,577	256,297	878,319	2,264,193		2,264,193	(9,428)	2,254,765			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 Bloomington Rehab & HCC #0047415 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,250	34,250		34,250	3,346	37,596			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,809	14,809		14,809	32,900	47,709			32
33	Real Estate Taxes			21,984	21,984		21,984	315	22,299			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,525	32,525		32,525	579	33,104			35
36	Other (specify):*											36
37	**TOTAL Ownership**			103,568	103,568		103,568	37,140	140,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,451		56,451		56,451		56,451			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,117	156,117		156,117		156,117			42
43	Other (specify):* Non-allowable Costs	32,180	2,017	82,039	116,236		116,236	(116,236)				43
44	**TOTAL Special Cost Centers**	32,180	58,468	238,156	328,804		328,804	(116,236)	212,568			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,161,757	314,765	1,220,043	2,696,565		2,696,565	(88,524)	2,608,041			45

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(402)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,022)	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	(87)	30		9
10	Interest and Other Investment Income	(6,964)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(17,115)	43		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	(51,404)	43		24
25	Fund Raising, Advertising and Promotional	(37,892)	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	(10,643)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (130,546)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	42,022	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,022		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (88,524)		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 Yes	2 No	3 Amount	4 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

Bloomington Rehab & HCC

ID# 0047415

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,497)	43	1
2	X-Rays-Part A	(589)	43	2
3	Special Events	298	43	3
4	Offset Miscellaneous Office Supplies Revenue	(495)	21	4
5	Offset Transportation Trans. Revenue	(5,985)	11	5
6	Offset Miscellaneous Nursing Supllies Revenue	(377)	10	6
7	Disallowed Resident Flowers	(39)	43	7
8	Disallowed Travel Air	(959)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,643)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	3,911	0	0	0	0	0	0	0	0	0	3,911	1
2	Food Purchase	(402)	84	0	0	0	0	0	0	0	0	0	(318)	2
3	Housekeeping	0	39	0	0	0	0	0	0	0	0	0	39	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	297	0	0	0	0	0	0	0	0	0	297	5
6	Maintenance	0	1,916	0	0	0	0	0	0	0	0	0	1,916	6
7	Other (specify):*	0	221	0	0	0	0	0	0	0	0	0	221	7
8	**TOTAL General Services**	(402)	6,468	0	0	0	0	0	0	0	0	0	6,066	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(377)	14	0	0	0	0	0	0	0	0	0	(363)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,985)	0	0	0	0	0	0	0	0	0	0	(5,985)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(6,362)	14	0	0	0	0	0	0	0	0	0	(6,348)	16
	C. General Administration													
17	Administrative	0	(174,860)	0	0	0	0	0	0	0	0	0	(174,860)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,247	0	95,555	0	0	0	0	0	0	0	103,802	19
20	Fees, Subscriptions & Promotions	0	0	524	825	0	0	0	0	0	0	0	1,349	20
21	Clerical & General Office Expenses	(495)	0	48,475	3,717	0	0	0	0	0	0	0	51,697	21
22	Employee Benefits & Payroll Taxes	0	0	0	(23)	0	0	0	0	0	0	0	(23)	22
23	Inservice Training & Education	0	0	78	0	0	0	0	0	0	0	0	78	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,621	0	0	0	0	0	0	0	0	3,621	25
26	Insurance-Prop.Liab.Malpractice	0	0	699	0	0	0	0	0	0	0	0	699	26
27	Other (specify):*	0	0	4,487	0	0	0	0	0	0	0	0	4,487	27
28	**TOTAL General Administration**	(495)	(166,613)	57,888	100,074	0	0	0	0	0	0	0	(9,146)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,259)	(160,131)	57,888	100,074	0	0	0	0	0	0	0	(9,428)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(87)	0	3,214	219	0	0	0	0	0	0	0	3,346	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,964)	0	5,346	34,518	0	0	0	0	0	0	0	32,900	32
33	Real Estate Taxes	0	0	315	0	0	0	0	0	0	0	0	315	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	579	0	0	0	0	0	0	0	0	579	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,051)	0	9,454	34,737	0	0	0	0	0	0	0	37,140	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(116,236)	0	0	0	0	0	0	0	0	0	0	(116,236)	43
44	**TOTAL Special Cost Centers**	(116,236)	0	0	0	0	0	0	0	0	0	0	(116,236)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(130,546)	(160,131)	67,342	134,811	0	0	0	0	0	0	0	(88,524)	45

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 PG6 - Supp		See PG6 - Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,911	$ 3,911	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	84	84	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	39	39	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	297	297	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,916	1,916	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	221	221	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	14	14	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	246,200	Petersen Health Care, Inc.	100.00%	71,340	(174,860)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	8,247	8,247	12
13	V								13
14	Total			$ 246,200			$ 86,069	$ * (160,131)	14

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 524	$ 524	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	48,475	48,475	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	78	78	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	4	4	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,621	3,621	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	699	699	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,487	4,487	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,214	3,214	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,346	5,346	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	315	315	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%	579	579	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			$			$ 67,342	$ * 67,342	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	95,555	95,555	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	825	825	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	3,717	3,717	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(23)	(23)	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	219	219	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	34,518	34,518	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			$			$ 134,811	$ * 134,811	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,560,986	75	$ 307,592	$ 295,212	19,850	$ 3,911	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	19,850	84	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	19,850	39	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	19,850	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	19,850	297	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	19,850	1,916	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	19,850	221	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	19,850	14	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	19,850	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	19,850	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	19,850	71,340	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	19,850	8,247	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	19,850	524	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	19,850	48,475	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	19,850	78	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	19,850	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	19,850	3,621	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	19,850	699	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	19,850	4,487	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	19,850	3,214	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	19,850	5,346	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	19,850	315	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	19,850	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	19,850	579	24
25	TOTALS					$ 11,032,372	$ 8,354,323		$ 153,411	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	408,598	21	$	$	19,850	$	1
2	2	Food	Resident Days	408,598	21			19,850		2
3	3	Housekeeping	Resident Days	408,598	21			19,850		3
4	4	Laundry	Resident Days	408,598	21			19,850		4
5	5	Utilities	Resident Days	408,598	21			19,850		5
6	6	Maintenance	Resident Days	408,598	21			19,850		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21			19,850		7
8	10	Nursing and Medical Records	Resident Days	408,598	21			19,850		8
9	12	Social Services	Resident Days	408,598	21			19,850		9
10	17	Administrative	Resident Days	408,598	21			19,850		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927		19,850	95,555	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972		19,850	825	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520		19,850	3,717	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)		19,850	(23)	14
15	23	Inservice Training & Education	Resident Days	408,598	21			19,850		15
16	24	Travel and Seminar	Resident Days	408,598	21			19,850		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21			19,850		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21			19,850		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21			19,850		19
20	30	Depreciation	Resident Days	408,598	21	4,500		19,850	219	20
21	32	Interest	Resident Days	408,598	21	710,525		19,850	34,518	21
22	33	Real Estate Taxes	Resident Days	408,598	21			19,850		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21			19,850		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21			19,850		24
25	TOTALS					$ 2,774,979	$		$ 134,811	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/19/07	$ 550,000	$ 410,367	12/31/13	Varies	$ 14,809	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 550,000	$ 410,367			$ 14,809	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(6,964)	11
12								Home Office Allocation-PHC			5,346	12
13								Home Office Allocation-PHO			34,518	13
14	TOTAL Non-Facility Related						$	$			$ 32,900	14
15	TOTALS (line 9+line14)						$ 550,000	$ 410,367			$ 47,709	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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.)

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 23,136	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.)	2012	$ 22,224	2
3. Under or (over) accrual (line 2 minus line 1).		$ (912)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 22,896	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.	Home Office Allocation 315		
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,299	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	27,455	8
	2009	22,437	9
	2010	22,626	10
	2011	22,458	11
	2012	22,224	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bloomington Rehab & HCC COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-16-128-012	Long-Term Care Facility	$ 22,223.98	$ 22,223.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,223.98	$ 22,223.98

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,386 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	66,211	2005	$ 87,500	1
2					2
3	TOTALS	66,211		$ 87,500	3

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		2005	1972	$ 528,930	$	30	$ 20,800	$ 20,800	$ 176,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvement			2005	13,000		15	867	867	7,369	9
10	Sign			2005	458		10	46	46	391	10
11	Sidewalks			2005	3,850		15	257	257	1,927	11
12	Roof			2007	9,076		20	454	454	3,178	12
13	Backflow			2008	9,779		25	392	392	2,156	13
14	Carpet			2008	6,911		7	988	988	5,434	14
15	Sprinkler Installation			2009	13,662		15	911	911	4,099	15
16	Water Service Line Repair			2009	5,990		7	856	856	3,852	16
17	Parking Lot Repair			2011	38,631		15	2,576	2,576	6,440	17
18	Sidewalk repair			2011	5,545		15	370	370	925	18
19	Sprinkler Work			2012	16,800		15	1,120	1,120	2,800	19
20	Water Leak Repair			2012	9,216		7	1,316	1,316	1,974	20
21	Roof Replacement			2013	60,115		25	1,202	1,202	1,202	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,236			(1,236)		30
31	Building Booked					20,827			(20,827)		31
32	Building Improvement Booked					9,722			(9,722)		32
33											33
34	2013-Home Office Allocation-Building Improvements				9,334			224	224		34
35	2013-Home Office Allocation-Land Improvements				871			56	56		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 Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 732,168	$ 31,785		$ 32,435	$ 650	$ 218,547	70

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 9,877	$ 1,193	$ 989	$ (204)	5-10 yrs.	$ 4,299	71
72	Current Year Purchases	20,378	1,272	1,019	(253)	10 yrs.	1,019	72
73	Fully Depreciated Assets	116,111					116,111	73
74	Home Office Allocation			3,153	3,153			74
75	TOTALS	$ 146,366	$ 2,465	$ 5,161	$ 2,696		$ 121,429	75

D. Vehicle Costs. (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)	$ 966,034	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,250	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,596	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,346	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 339,976	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 23,435 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250	$ 829	$ 9,669	17
18					18
19					19
20					20
21	TOTAL		$ 828.89	$ 9,669	21

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

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

Bloomington Rehab & HCC
0047415
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 15,599
Dishwasher	713
Laundry Equipment	-
Copier	6,544
Home Office Allocation	579
	23,435

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,603	$ 99,040	$	6,603	$ 99,040	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,520	22,805		1,520	22,805	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,462	126,925		8,462	126,925	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				56,451		56,451	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			$	16,585	$ 248,770	$ 56,451	16,585	$ 305,221	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.

STATE OF ILLINOIS

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 473,625	$ 473,625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,430)	449,677	449,677	3
4	Supply Inventory (priced at)	8,321	8,321	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,434	27,434	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Lease	4,437	4,437	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 963,494	$ 963,494	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,045	87,500	13
14	Buildings, at Historical Cost	520,000	538,264	14
15	Leasehold Improvements, at Historical Cost	170,180	193,904	15
16	Equipment, at Historical Cost	146,822	146,366	16
17	Accumulated Depreciation (book methods)	(330,738)	(339,976)	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)**	$ 612,309	$ 626,058	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,575,803	$ 1,589,552	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,481,123	$ 1,481,123	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,017	23,017	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,650	4,650	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,896	22,896	32
33	Accrued Interest Payable	1,120	1,120	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	39,337	39,337	36
37	Accrued Management Fees	229,966	229,966	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,802,109	$ 1,802,109	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	410,367	410,367	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)**	$ 410,367	$ 410,367	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,212,476	$ 2,212,476	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (636,673)	$ (622,924)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,575,803	$ 1,589,552	48

*(See instructions.)

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (682,056)	1	
2	Restatements (describe):		2	
3	**Rounding**	3	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (682,053)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	45,380	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)**	$ 45,380	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)**	$ (636,673)	24	*

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,495,996	1
2	Discounts and Allowances for all Levels	(271,836)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,224,160	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	345,896	6
7	Oxygen	258	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 346,154	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	402	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	110,360	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,003	20
21	Other Medical Services	4,391	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,156	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,964	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,964	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	40,526	28
28a	Transportation Revenue	5,985	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,511	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,741,945	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	462,327	31
32	Health Care	1,230,268	32
33	General Administration	571,598	33
	B. Capital Expense		
34	Ownership	103,568	34
	C. Ancillary Expense		
35	Special Cost Centers	172,687	35
36	Provider Participation Fee	156,117	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,696,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	45,380	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 45,380	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,802,794	44
45	Private Pay - Net Inpatient Revenue	253,102	45
46	Medicare - Net Inpatient Revenue	194,444	46
47	Other-(specify) Charity and Insurance Contractual Allowance	(26,180)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,224,160	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,167	2,167	$ 68,495	$ 31.61	1
2	Assistant Director of Nursing	1,817	1,817	38,371	21.12	2
3	Registered Nurses	6,262	6,640	174,379	26.26	3
4	Licensed Practical Nurses	8,183	8,438	173,514	20.56	4
5	CNAs & Orderlies	29,514	30,612	353,314	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,377	1,461	20,491	14.03	9
10	Activity Assistants	846	873	11,290	12.93	10
11	Social Service Workers	583	583	8,747	15.00	11
12	Dietician					12
13	Food Service Supervisor	696	696	8,570	12.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,896	8,985	82,368	9.17	15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,058	39,908	19.39	17
18	Housekeepers	5,540	5,915	59,835	10.12	18
19	Laundry	3,232	3,349	34,757	10.38	19
20	Administrator	2,080	2,080	71,340	34.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,916	2,074	38,015	18.33	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	2,836	2,908	49,703	17.09	33
34	TOTAL (lines 1 - 33)	77,856	80,656	$ 1,233,097 *	$ 15.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,947	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	110	L10, C3	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)	2	$ 17,057		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	262	6,182	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	262	$ 6,182		53

Bloomington Rehabilitation & Health Care Center
0047415
Period Beginning **1/1/2013**
Period End **12/31/2013**

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	460	460	8,279	18.00
Transportation	579	579	9,244	15.97
Marketing	1,797	1,869	32,180	17.22
TOTAL	2,836	2,908	49,703	

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Kindred	Administrator	0	$ 71,340
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,340

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 246,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 246,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 6,763
Frontier	Computer Services	677
Consolidated Land Survey	Surveying Fees	2,500
Honkamp Kruger	Accounting Fees	1,425
Sorling, Northrup	Legal Fees	4,725
Gail and Rice	Accounting Fees	614
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 16,704

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,540
Unemployment Compensation Insurance	35,400
FICA Taxes	87,070
Employee Health Insurance	23,303
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,949
Employee Retirement	58
Home Office Allocation	(23)
TOTAL (agree to Schedule V, line 22, col.8)	$ 189,297

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 96	961
Miscellaneous Licenses & Permits	504
Miscellaneous Dues & Subscriptions	0
Home Office Allocation	1,349
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,804

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4

**See instructions.

Bloomington Rehab & HCC
0047415
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		16,704
Home Office Allocation		
SmithAmundsen	Legal	490
Cole, Schotz, Meisel	Legal	270
Black, Hedin, Ballard	Legal	24
Elias, Meginnes, Riffle & Seghetti	Legal	49
Miller, Hall, and Triggs	Legal	1032
Evapar	Legal	199
Ginoli & Company	Accountants	2838
E-Health Data Solutions	Computer Services	3530
Miscellaneous	Computer Services	77
Odessian LLC	Computer Services	38
CCH	Computer Services	11
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	10
Macquarie Technology Services	Computer Services	70
Advanced Answers on Demand	Computer Services	3630
TeamViewer	Computer Services	12
Stratus Networks	Computer Services	293
Kemper Technology	Computer Services	226
AT&T	Computer Services	4
Medifax	Computer Services	33
Vision Share/Ability Network	Computer Services	497
Barracuda	Computer Services	90
CIAN	Computer Services	119
Comcast	Computer Services	27
Emdeon	Computer Services	40

Marotta Gund Budd & Dzera	Other Prof Fees	88605
David Budde	Other Prof Fees	23
Pharmacy Price Mangement	Other Prof Fees	457
All Scripts	Other Prof Fees	813
Registered Agent Solutions	Other Prof Fees	38
Healthink	Other Prof Fees	253
Total (agree to Schedule V, line 19, column 8)		120,506

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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? **No**
If YES, give association name and amount.

(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. $ **19,183** 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. $ **156,117**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **402**

(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. $ **5,985**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(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 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Bloomington Rehab & H** **02:02 PM** **5/20/2014**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-88,524	equal to	-88,524	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	47,709	equal to	47,709	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	22,299	equal to	22,299	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	37,596	equal to	37,596	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	33,104	equal to	33,104	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	248,770	equal to	248,770	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	56,451	equal to	56,451	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	462,327	equal to	462,327	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,230,268	equal to	1,230,268	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	571,598	equal to	571,598	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	103,568	equal to	103,568	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	172,687	equal to	172,687	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	156,117	equal to	156,117	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	816,352	equal to	816,352	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,025	equal to	41,025	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	8,747	equal to	8,747	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	90,938	equal to	90,938	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	39,908	equal to	39,908	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	59,835	equal to	59,835	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,757	equal to	34,757	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	71,340	equal to		71,340	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	38,015	equal to	38,015	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,233,097	equal to	1,161,757	71,340	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,000	< or = to	13,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	10,239	< or = to	10,771	-532	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	714	-714	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	71,340	equal to		71,340	FAILED	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	246,200	equal to	246,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	16,704	equal to	16,704	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	189,297	equal to	189,297	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,804	equal to	4,804	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4	equal to	4	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	156,117	equal to	156,117	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	-23	23	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	826	equal to	826	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	42,022	equal to	42,022	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	410,367	equal to	410,367	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	22,896	equal to	22,896	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	87,500	equal to	87,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	732,168	equal to	732,168	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	146,366	equal to	146,366	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	339,976	equal to	339,976	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-636,673	equal to	-636,673	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	45,380	equal to	45,380	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,575,803	equal to	1,575,803	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	90,938	12,836	0	103,774	0	103,774	3,911	107,685
2. Food Purchase	0	105,569	0	105,569	0	105,569	-318	105,251
3. Housekeeping	59,835	19,014	0	78,849	0	78,849	39	78,888
4. Laundry	34,757	15,435	0	50,192	0	50,192	0	50,192
5. Heat and Other Utilities	0	0	59,839	59,839	0	59,839	297	60,136
6. Maintenance	39,908	9,477	14,719	64,104	0	64,104	1,916	66,020
7. Other (specify)*	0	0	0	0	0	0	221	221
8. Total General Services	225,438	162,331	74,558	462,327	0	462,327	6,066	468,393
9. Medical Director	0	0	13,000	13,000	0	13,000	0	13,000
10. Nursing & Medical Records	816,352	90,599	10,771	917,722	0	917,722	-363	917,359
10a. Therapy	0	0	248,770	248,770	0	248,770	0	248,770
11. Activities	41,025	290	714	42,029	0	42,029	-5,985	36,044
12. Social Services	8,747	0	0	8,747	0	8,747	0	8,747
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	866,124	90,889	273,255	1,230,268	0	1,230,268	-6,348	1,223,920
17. Administrative	0	0	246,200	246,200	0	246,200	-174,860	71,340
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	16,704	16,704	0	16,704	103,802	120,506
20. Fees, Subscriptions & Promotion	0	0	3,455	3,455	0	3,455	1,349	4,804
21. Clerical & General Office	38,015	3,077	35,114	76,206	0	76,206	51,697	127,903
22. Employee Benefits & Payroll	0	0	189,320	189,320	0	189,320	-23	189,297
23. Inservice Training & Education	0	0	264	264	0	264	78	342
24. Travel and Seminar	0	0	0	0	0	0	4	4
25. Other Admin. Staff Trans	0	0	10,568	10,568	0	10,568	3,621	14,189
26. Insurance-Prop.Liab.Malpractice	0	0	28,881	28,881	0	28,881	699	29,580
27. Other (specify)*	0	0	0	0	0	0	4,487	4,487
28. Total General Adminis	38,015	3,077	530,506	571,598	0	571,598	-9,146	562,452
29. Total General Administrative	1,129,577	256,297	878,319	2,264,193	0	2,264,193	-9,428	2,254,765
30. Depreciation	0	0	34,250	34,250	0	34,250	3,346	37,596
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	14,809	14,809	0	14,809	32,900	47,709
33. Real Estate	0	0	21,984	21,984	0	21,984	315	22,299

34.	Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35.	Rent - Equipment & Vehicles		0	0	32,525	32,525	0	32,525	579	33,104
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	103,568	103,568	0	103,568	37,140	140,708
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	56,451	0	56,451	0	56,451	0	56,451
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	156,117	156,117	0	156,117	0	156,117
43.	Other (specify):*		32,180	2,017	82,039	116,236	0	116,236	-116,236	0
44.	Total Special Cost Ce		32,180	58,468	238,156	328,804	0	328,804	-116,236	212,568
45.	Grand Total		1,161,757	314,765	1,220,043	2,696,565	0	2,696,565	-88,524	2,608,041

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	675	675
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	449,677	449,677
4. Supply Inventory	8,321	8,321
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,434	27,434
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	4,437	4,437
10. Total current assets	490,544	490,544
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	106,045	87,500
14. Buildings, at Historical Cost	520,000	538,264
15. Leasehold Improvements, Historical Cost	170,180	193,904
16. Equipment, at Historical Cost	146,822	146,366
17. Accumulated Depreciation (book methods)	-330,738	-339,976
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	612,309	626,058
25. Total Assets	1,102,853	1,116,602
CURRENT LIABILITIES		
26. Accounts Payable	1,008,173	1,008,173
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	23,017	23,017
31. Accrued Taxes Payable	4,650	4,650
32. Accrued Real Estate Taxes	22,896	22,896
33. Accrued Interest Payable	1,120	1,120
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	39,337	39,337

37. Other Current Liabilities (specify):	229,966	229,966
38. Total Current Liabilities	1,329,159	1,329,159
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	410,367	410,367
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	410,367	410,367
46.Total Liabilities	1,739,526	1,739,526
47.Total Equity	-636,673	-622,924
48.Total Liabilities and Equity	1,102,853	1,116,602

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,495,996
2. Discounts and Allowances for all Levels	-271,836
Subtotal - Inpatient Care	2,224,160
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	345,896
7. Oxygen	258
Subtotal - Anciliary Revenue	346,154
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	402
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	110,360
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	3,003
21. Other Medical Services	4,391
22. Laundry	0
Subtotal - Other Operating Revenue	118,156
24. Contributions	0
25. Interest and Other Investments Income	6,964
Subtotal - Non-Operating Revenue	6,964
27. Other Revenue (specify):	0
28. Other Revenue (specify):	46,511
Subtotal - Other Revenue	46,511
30. Total Revenue	2,741,945
31. General Services	417,774
32. Health Care	1,218,546
33. General Administration	460,893
34. Ownership	145,981

35.	Special Cost Centers	164,569
35.	Provider Participation Fee	204,600
37.	Other	0
40.	Total Expenses	2,612,363
41.	Income Before Income Taxes	129,582
42.	Income Taxes	0
43.	Net Income or Loss for the Year	129,582

Enter Cost Center Expenses **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 5/20/2014 02:02:33 PM

HSA Number: 5 Name: **Bloomington Rehab & HCC**

Cost report period From: 1/1/2013 To: 12/31/2013 Base Number: 456

If this is an ICF/DD 16 facility, enter a 1 in cell C6 N

Licensed bed days: 28,470 Occupancy: 19,850 Pct. of occupancy: 69.72%

Illinois Public Aid Support Rate: $

Genl Services Salary/Wage:	225,438	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage:	38,015	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage:	1,161,757	Col 1, Line 44 ---Audit Adj:	
Employee Benefits:	189,297	Col 8, Line 22 ---Audit Adj:	
Total General Services:	468,393	Col 8, Line 8 ---Audit Adj:	
Total General Admin:	562,452	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month =	13	divided by 2 =
Beginning Day + Ending Day =	32	divided by 60.8 =
Beginning Year + Ending Year =	226	multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

$225,438
$1,161,757
19.4049%
$189,297

$36,733
$468,393
$505,126

$38,015
$1,161,757
3.2722%

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

	$189,297
	$6,194
	$562,452
	$189,297
	$379,349
	6.5
	0.526315789
	1356
	1363.026316
	907.00
	456
	1
	1
	$505,126
	1
	$505,126

$379,349	
1	
	$379,349
	$884,475
$40.10	
$884,475	
19,850	
$44.56	
28,470	
0.93	
26,477	
19,850	
6,627	
2,209	
19,850	
22,059	

$884,475
22059

$40.10

$41.31
$40.10

$1.21

0.5

$0.61

$40.10

40.71

$41.31
$40.10

$1.21

0.5

$0.61

3.645

$0.610

$40.10

$40.71

$40.71

$41.31
$34.45

F/DD 16 Facilities)
rcentiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655