FOR BHF USE

LL1

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

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.

I. IDPH License ID Number: 0046425

Facility Name: Sullivan Rehab & HCC

Address: 11 Hawthorne Lane (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4327 **Fax #** (217) 728-2263

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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 Sullivan Rehab & HCC # 0046425 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	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	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	13,892	3,657	2,439	19,988	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,892	3,657	2,439	19,988	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.52%

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)
Meals on Wheels

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 9/3/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/3/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 2,187

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 Sullivan Rehab & HCC # 0046425 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	154,551	13,450		168,001		168,001	3,939	171,940			1
2	Food Purchase		121,375		121,375		121,375	(4,380)	116,995			2
3	Housekeeping	112,476	23,211		135,687		135,687	39	135,726			3
4	Laundry	988	10,324		11,312		11,312		11,312			4
5	Heat and Other Utilities			172,863	172,863		172,863	299	173,162			5
6	Maintenance	32,609	15,683	15,441	63,733		63,733	1,939	65,672			6
7	Other (specify):* Home Off. Ben. All.							223	223			7
8	TOTAL General Services	300,624	184,043	188,304	672,971		672,971	2,059	675,030			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	931,053	125,582	38,093	1,094,728		1,094,728	14	1,094,742			10
10a	Therapy	24,700	430	184,476	209,606		209,606		209,606			10a
11	Activities	23,109	1,074	34,658	58,841		58,841	(430)	58,411			11
12	Social Services	34,157			34,157		34,157		34,157			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,013,019	127,086	268,227	1,408,332		1,408,332	(416)	1,407,916			16
	C. General Administration											
17	Administrative			215,800	215,800		215,800	(152,800)	63,000			17
18	Directors Fees											18
19	Professional Services			4,863	4,863		4,863	16,021	20,884			19
20	Dues, Fees, Subscriptions & Promotions			6,305	6,305		6,305	(330)	5,975			20
21	Clerical & General Office Expenses	27,403	6,657	24,521	58,581		58,581	59,639	118,220			21
22	Employee Benefits & Payroll Taxes			197,778	197,778		197,778	478	198,256			22
23	Inservice Training & Education							79	79			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			3,136	3,136		3,136	3,646	6,782			25
26	Insurance-Prop.Liab.Malpractice			44,473	44,473		44,473	704	45,177			26
27	Other (specify):* Home Off. Ben. All.							4,518	4,518			27
28	TOTAL General Administration	27,403	6,657	496,876	530,936		530,936	(68,041)	462,895			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,341,046	317,786	953,407	2,612,239		2,612,239	(66,398)	2,545,841			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 Sullivan Rehab & HCC #0046425 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			53,492	53,492		53,492	18,760	72,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,279	71,279		71,279	81,711	152,990			32
33	Real Estate Taxes			46,364	46,364		46,364	317	46,681			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,790	25,790		25,790	583	26,373			35
36	Other (specify):*											36
37	**TOTAL Ownership**			196,925	196,925		196,925	101,371	298,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,565		107,565		107,565		107,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,513	173,513		173,513		173,513			42
43	Other (specify):* Non-allowable Costs		838	60,777	61,615		61,615	(61,615)				43
44	**TOTAL Special Cost Centers**		108,403	234,290	342,693		342,693	(61,615)	281,078			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,341,046	426,189	1,384,622	3,151,857		3,151,857	(26,642)	3,125,215			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 Sullivan Rehab & HCC # 0046425 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,464)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,276)	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	(3,089)	30		9
10	Interest and Other Investment Income	(12,117)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(261)	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	(26,765)	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	(15)	43		24
25	Fund Raising, Advertising and Promotional	(3,723)	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	(21,652)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (83,362)		$	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)	56,720	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 56,720		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (26,642)		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

STATE OF ILLINOIS **Page 5A**

Sullivan Rehab & HCC

ID# **0046425**

Report Period Beginning: **1/1/2013**

Ending: **12/31/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,162)	43	1
2	X-Rays-Part A	(5,081)	43	2
3	Resident Flowers	(712)	43	3
4	Offset Miscellaneous Transportation Revenue	(430)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(789)	21	5
6	Pet Expense	(935)	43	6
7	Offset Chamber of Commerce Dues	(858)	20	7
8	Disallowed Air Plane Expense	(6,686)	43	8
9	Disallowed Special Event	1	43	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**	(21,652)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 **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	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)	
	A. General Services													
1	Dietary	0	3,939	0	0	0	0	0	0	0	0	0	3,939	1
2	Food Purchase	(4,464)	84	0	0	0	0	0	0	0	0	0	(4,380)	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	299	0	0	0	0	0	0	0	0	0	299	5
6	Maintenance	0	1,929	0	10	0	0	0	0	0	0	0	1,939	6
7	Other (specify):*	0	223	0	0	0	0	0	0	0	0	0	223	7
8	**TOTAL General Services**	(4,464)	6,513	0	10	0	0	0	0	0	0	0	2,059	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	0	14	0	0	0	0	0	0	0	0	0	14	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(430)	0	0	0	0	0	0	0	0	0	0	(430)	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**	(430)	14	0	0	0	0	0	0	0	0	0	(416)	16
	C. General Administration													
17	Administrative	0	(152,800)	0	0	0	0	0	0	0	0	0	(152,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,304	0	7,717	0	0	0	0	0	0	0	16,021	19
20	Fees, Subscriptions & Promotions	(858)	0	528	0	0	0	0	0	0	0	0	(330)	20
21	Clerical & General Office Expenses	(789)	0	48,812	11,616	0	0	0	0	0	0	0	59,639	21
22	Employee Benefits & Payroll Taxes	0	0	0	478	0	0	0	0	0	0	0	478	22
23	Inservice Training & Education	0	0	79	0	0	0	0	0	0	0	0	79	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	3,646	0	0	0	0	0	0	0	0	3,646	25
26	Insurance-Prop.Liab.Malpractice	0	0	704	0	0	0	0	0	0	0	0	704	26
27	Other (specify):*	0	0	4,518	0	0	0	0	0	0	0	0	4,518	27
28	**TOTAL General Administration**	(1,647)	(144,496)	58,291	19,811	0	0	0	0	0	0	0	(68,041)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,541)	(137,969)	58,291	19,821	0	0	0	0	0	0	0	(66,398)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 **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	(3,089)	0	3,236	18,613	0	0	0	0	0	0	0	18,760	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,117)	0	5,383	88,445	0	0	0	0	0	0	0	81,711	32
33	Real Estate Taxes	0	0	317	0	0	0	0	0	0	0	0	317	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	583	0	0	0	0	0	0	0	0	583	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,206)	0	9,519	107,058	0	0	0	0	0	0	0	101,371	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):*	(61,615)	0	0	0	0	0	0	0	0	0	0	(61,615)	43
44	**TOTAL Special Cost Centers**	(61,615)	0	0	0	0	0	0	0	0	0	0	(61,615)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(83,362)	(137,969)	67,810	126,879	0	0	0	0	0	0	0	(26,642)	45

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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. [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)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,939	$ 3,939	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%	299	299	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,929	1,929	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	223	223	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	215,800	Petersen Health Care, Inc.	100.00%	63,000	(152,800)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	8,304	8,304	12
13	V								13
14	Total			$ 215,800			$ 77,831	$ * (137,969)	14

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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%	$ 528	$ 528	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	48,812	48,812	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	79	79	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%	3,646	3,646	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	704	704	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,518	4,518	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,236	3,236	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,383	5,383	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	317	317	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%	583	583	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			$			$ 67,810	$ * 67,810	39

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 Care II, Inc.	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	10	10	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12	Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	7,717	7,717	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	11,616	11,616	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	478	478	28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	18,613	18,613	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	88,445	88,445	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	0		38
39	Total			$			$ 126,879	$ * 126,879	39

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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	19,988	$ 3,939	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	19,988	84	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	19,988	39	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	19,988	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	19,988	299	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	19,988	1,929	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	19,988	223	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	19,988	14	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	19,988	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	19,988	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	19,988	63,000	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	19,988	8,304	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	19,988	528	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	19,988	48,812	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	19,988	79	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	19,988	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	19,988	3,646	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	19,988	704	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	19,988	4,518	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	19,988	3,236	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	19,988	5,383	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	19,988	317	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	19,988	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	19,988	583	24
25	TOTALS					$ 11,032,372	$ 8,354,323		$ 145,641	25

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 II, 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	161,888	7	$	$	19,988	$	1
2	2	Food	Resident Days	161,888	7			19,988		2
3	3	Housekeeping	Resident Days	161,888	7			19,988		3
4	4	Laundry	Resident Days	161,888	7			19,988		4
5	5	Utilities	Resident Days	161,888	7			19,988		5
6	6	Maintenance	Resident Days	161,888	7	80		19,988	10	6
7	7	Mgmt. Allocation of Benefits	Resident Days	161,888	7			19,988		7
8	10	Nursing and Medical Records	Resident Days	161,888	7			19,988		8
9	15	Mgmt. Allocation of Benefits	Resident Days	161,888	7			19,988		9
10	17	Administrative	Resident Days	161,888	7			19,988		10
11	19	Professional Services	Resident Days	161,888	7	62,499		19,988	7,717	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	161,888	7			19,988		12
13	21	Clerical and General Office	Resident Days	161,888	7	94,081		19,988	11,616	13
14	22	Employee Benefits & Payroll	Resident Days	161,888	7	3,874		19,988	478	14
15	23	Inservice Training & Education	Resident Days	161,888	7			19,988		15
16	24	Travel and Seminar	Resident Days	161,888	7			19,988		16
17	25	Other Admin. Staff Transport.	Resident Days	161,888	7			19,988		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	161,888	7			19,988		18
19	27	Mgmt. Allocation of Benefits	Resident Days	161,888	7			19,988		19
20	30	Depreciation	Resident Days	161,888	7	150,752		19,988	18,613	20
21	32	Interest	Resident Days	161,888	7	716,337		19,988	88,445	21
22	33	Real Estate Taxes	Resident Days	161,888	7			19,988		22
23	34	Rent-Facility and Grounds	Resident Days	161,888	7			19,988		23
24	35	Rent-Equipment & Vehicles	Resident Days	161,888	7			19,988		24
25	TOTALS					$ 1,027,623	$		$ 126,879	25

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Merit		X	Mortgage	Varies	2/1/12	$ 1,743,600	$ 1,654,815	1/31/17	Varies	$ 71,279	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,743,600	$ 1,654,815			$ 71,279	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(12,117)	11
12								Home Office Allocation-PHC			5,383	12
13								Home Office Allocation-PHC II			88,445	13
14	TOTAL Non-Facility Related						$	$			$ 81,711	14
15	TOTALS (line 9+line14)						$ 1,743,600	$ 1,654,815			$ 152,990	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 Sullivan Rehab & HCC # 0046425 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.**		$ 45,660	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	$ 45,332	2
3. Under or (over) accrual (line 2 minus line 1).		$ (328)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 46,692	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**		317	
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.		$ 46,681	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	41,471	8
	2009	42,056	9
	2010	42,469	10
	2011	44,333	11
	2012	45,332	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 Sullivan Rehab & HCC COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

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.	08-08-11-400-004	Long-Term Care Facility	$ 44,972.16	$ 44,972.16
2.	08-08-12-300-073	Long-Term Care Facility	$ 359.88	$ 359.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,332.04	$ 45,332.04

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 Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete 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	339,095	2003	$ 100,001	1
2					2
3	TOTALS	339,095		$ 100,001	3

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	123		2003	1975	$ 1,560,545	$	39	$ 40,014	$ 40,014	$ 413,478	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2004	4,808		25	192	192	1,776	9
10	Fire Alarms			2004	1,524		25	61	61	539	10
11	Doors			2004	3,067		5			3,067	11
12	Smoke Alarms			2004	1,227		7			1,227	12
13	Land Improvements			2006	7,262		15	484	484	3,630	13
14	New Roof			2006	28,308		25	1,132	1,132	8,490	14
15	Kitchen Remodel			2006	22,241		25	890	890	6,675	15
16	Landscaping			2006	2,434		15	162	162	1,215	16
17	Sidewalks			2007	1,785		15	120	120	780	17
18	Sprinkler System			2008	14,839		25	594	594	3,267	18
19	Back Flow			2009	5,470		7	782	782	3,519	19
20	Water Heater			2009	2,983		5	596	596	2,682	20
21	Roof Repairs			2011	2,536		7	362	362	905	21
22	Nurses Station			2013	17,449		15	582	582	582	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					765			(765)		30
31	Building Booked					40,014			(40,014)		31
32	Building Improvement Booked					4,559			(4,559)		32
33											33
34	2013-Home Office Allocation-Building Improvements				9,398			225	225		34
35	2013-Home Office Allocation-Land Improvements				877			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 Sullivan Rehab & HCC # 0046425 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)		$ 1,686,753	$ 45,338		$ 46,252	$ 914	$ 451,832	70

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	$ 38,366	$ 7,179	$ 3,836	$ (3,343)	5-10 yrs.	$ 21,648	71
72	Current Year Purchases	11,909	975	596	(379)	10 yrs.	596	72
73	Fully Depreciated Assets	615,105					615,105	73
74	Home Office Allocation			21,568	21,568			74
75	TOTALS	$ 665,380	$ 8,154	$ 26,000	$ 17,846		$ 637,349	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	Facility	2003 Ford	2003	$ 31,116	$		$		$ 31,116	76
77										77
78										78
79										79
80	TOTALS			$ 31,116	$	$	$		$ 31,116	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)	$ 2,483,250	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,492	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,252	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,760	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,120,297	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 Sullivan Rehab & HCC # 0046425 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: $ 16,786 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 Van	$ 822.05	$ 9,587	17
18					18
19					19
20					20
21	TOTAL		$ 822.05	$ 9,587	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.

Sullivan Rehab & HCC
0046425
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	$ 11,384
Dishwasher	-
Laundry Equipment	-
Copier	4,819
Home Office Allocation	583
	16,786

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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	$	2,031	$ 30,471	$	2,031	$ 30,471	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		1,318	19,773		1,318	19,773	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(3)	1,757	hrs	24,700	8,942	134,127		430	158,827	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				106,154		106,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Therapy Veterans	10A(3)						1,411		1,411	12
13	Other (specify): Respiratory Therapy	10A(3)				7	105		7	105	13
14	TOTAL				$ 24,700	12,298	$ 184,476	$ 107,565	3,787	$ 316,741	14

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	$ 1,690,980	$ 1,690,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 122,588)	778,752	778,752	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,502	42,502	6
7	Other Prepaid Expenses	13,122	13,122	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	4,328	4,328	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,529,684	$ 2,529,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,569,943	14
15	Leasehold Improvements, at Historical Cost	100,156	116,810	15
16	Equipment, at Historical Cost	700,791	696,496	16
17	Accumulated Depreciation (book methods)	(1,126,428)	(1,120,297)	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): PPD Lease/Mgmt/Other	24,447	24,447	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,370,992	$ 1,387,400	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,900,676	$ 3,917,084	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 442,304	$ 442,304	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,042	94,042	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,913	4,913	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,692	46,692	32
33	Accrued Interest Payable	5,935	5,935	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	48,349	48,349	36
37	Accrued Management Fees	15,063	15,063	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 657,298	$ 657,298	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,654,815	1,654,815	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other & IL State Police	38,006	38,006	43
44	Due to From	406,204	406,204	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,099,025	$ 2,099,025	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,756,323	$ 2,756,323	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,144,353	$ 1,160,761	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,900,676	$ 3,917,084	48

*(See instructions.)

Facility Name & ID Number Sullivan Rehab & HCC **#** 0046425 **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**	$ 1,374,988	1	
2	Restatements (describe):		2	
3	**Rounding**	(5)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,374,983	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(230,630)	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)**	$ (230,630)	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)**	$ 1,144,353	24	*

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	$ 2,744,208	1
2	Discounts and Allowances for all Levels	(467,593)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,276,615	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	396,397	6
7	Oxygen	964	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 397,361	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	4,464	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	200,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,835	20
21	Other Medical Services	17,127	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 233,915	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,117	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,117	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	789	28
28a	Transportation Revenue	430	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,219	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,921,227	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	672,971	31
32	Health Care	1,408,332	32
33	General Administration	530,936	33
	B. Capital Expense		
34	Ownership	196,925	34
	C. Ancillary Expense		
35	Special Cost Centers	169,180	35
36	Provider Participation Fee	173,513	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,151,857	40
41	**Income before Income Taxes (line 30 minus line 40)****	(230,630)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (230,630)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,479,705	44
45	Private Pay - Net Inpatient Revenue	510,450	45
46	Medicare - Net Inpatient Revenue	319,238	46
47	Other-(specify) Veterans -Net Patient Revenue	1,033	47
48	Other-(specify) Charity and Insurance Contractual Allowance	(33,811)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,276,615	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 Sullivan Rehab & HCC # 0046425 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	2,080	2,080	$ 67,891	$ 32.64	1
2	Assistant Director of Nursing	780	838	17,599	21.00	2
3	Registered Nurses	512	512	11,655	22.76	3
4	Licensed Practical Nurses	15,906	16,315	322,950	19.79	4
5	CNAs & Orderlies	41,529	42,338	462,401	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,622	1,757	24,700	14.06	8
9	Activity Director	1,853	1,981	23,109	11.67	9
10	Activity Assistants					10
11	Social Service Workers	1,824	2,008	34,157	17.01	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	38,147	18.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,623	13,306	116,404	8.75	15
16	Dishwashers					16
17	Maintenance Workers	2,012	2,100	32,609	15.53	17
18	Housekeepers	11,177	11,706	112,476	9.61	18
19	Laundry	111	111	988	8.90	19
20	Administrator	2,080	2,080	63,000	30.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	27,403	13.17	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) CPC	2,056	2,080	48,557	23.34	33
34	TOTAL (lines 1 - 33)	100,325	103,372	$ 1,404,046 *	$ 13.58	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	11,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,087	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	9	425	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)	9	$ 15,512		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	205	$ 6,771	L10, C3	50
51	Licensed Practical Nurses	1,107	24,557	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,312	$ 31,328		53

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chuck Pullen	Administrator	0	$ 63,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 215,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 215,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Citizens Abstract Company	Filing Fees	$ 150
Mediacom	Computer Services	1,391
Honkamp, Krueger and Co.	Accounting Services	820
Moultrie Co. Circuit Clerk	Filing Fees	2
Mary J Dyck	Legal Fees	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,863

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,558
Unemployment Compensation Insurance	33,990
FICA Taxes	95,848
Employee Health Insurance	7,118
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	5,555
Employee Retirement	1,709
Home Office Allocation	478
TOTAL (agree to Schedule V, line 22, col.8)	$ 198,256

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 517	5,172
Miscellaneous Licenses & Permits	275
Miscellaneous Dues & Subscriptions	858
Home Office Allocation	528
Less: Public Relations Expense	(858)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,975

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.

Sullivan Rehab & HCC
0046425
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)		4,863
Home Office Allocation		
SmithAmundsen	Legal	494
Cole, Schotz, Meisel	Legal	272
Black, Hedin, Ballard	Legal	25
Medicare	Legal	270
Estate of Dorothy Frolker	Legal	284
Ginoli & Company	Accountants	5953
IC System	Computer Services	848
Miscellaneous	Computer Services	78
Odessian LLC	Computer Services	39
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	3655
TeamViewer	Computer Services	12
Stratus Networks	Computer Services	295
Kemper Technology	Computer Services	228
AT&T	Computer Services	4
Medifax	Computer Services	33
Vision Share/Ability Network	Computer Services	500
Barracuda	Computer Services	90
CIAN	Computer Services	120
Comcast	Computer Services	27
Emdeon	Computer Services	40
Marotta Gund Budd & Dzera	Other Prof Fees	1119

David Budde	Other Prof Fees	23
Pharmacy Price Mangement	Other Prof Fees	92
All Scripts	Other Prof Fees	165
Pinnacle Actuarial Resources	Other Prof Fees	1230
Healthlink	Other Prof Fees	30
Total (agree to Schedule V, line 19, column 8)		20,884

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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. $ **12,840** 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. $ **173,513**
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. $ **4,464**

(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. $ **430**
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.