FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0053496

Facility Name: Aspen Rehab & Hlth Care Ctr

Address: 1403 9th Avenue (Number) Silvis (City) 61282 (Zip Code)

County: Rock Island

Telephone Number: (309) 796-2600 **Fax #** (309) 796-2981

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

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 1/1/14 to 12/31/14 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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	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					8
9	SNF/PED					9
10	ICF	14,912	1,656		16,568	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,912	1,656		16,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.05%

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 [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	120,026	6,864		126,890		126,890	5,600	132,490			1
2	Food Purchase		100,416		100,416		100,416	(328)	100,088			2
3	Housekeeping	58,923	13,688		72,611		72,611	35	72,646			3
4	Laundry	56,265	2,834		59,099		59,099		59,099			4
5	Heat and Other Utilities			52,971	52,971		52,971	211	53,182			5
6	Maintenance	26,883	13,319	40,625	80,827		80,827	2,106	82,933			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	262,097	137,121	93,596	492,814		492,814	7,624	500,438			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	20	18,020			9
10	Nursing and Medical Records	707,992	56,229	3,514	767,735		767,735	(119)	767,616			10
10a	Therapy		27		27		27		27			10a
11	Activities	17,863	696	450	19,009		19,009	(5,829)	13,180			11
12	Social Services	27,833	33		27,866		27,866		27,866			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	753,688	56,985	21,964	832,637		832,637	(5,928)	826,709			16
	C. General Administration											
17	Administrative			200,400	200,400		200,400	(136,433)	63,967			17
18	Directors Fees											18
19	Professional Services			7,455	7,455		7,455	70,456	77,911			19
20	Dues, Fees, Subscriptions & Promotions			5,968	5,968		5,968	(357)	5,611			20
21	Clerical & General Office Expenses	21,451	3,194	40,288	64,933		64,933	62,018	126,951			21
22	Employee Benefits & Payroll Taxes			144,647	144,647		144,647	14,679	159,326			22
23	Inservice Training & Education							25	25			23
24	Travel and Seminar							22	22			24
25	Other Admin. Staff Transportation			11,408	11,408		11,408	3,400	14,808			25
26	Insurance-Prop.Liab.Malpractice			21,755	21,755		21,755	490	22,245			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	21,451	3,194	431,921	456,566		456,566	14,300	470,866			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,037,236	197,300	547,481	1,782,017		1,782,017	15,996	1,798,013			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 Aspen Rehab & Hlth Care Ctr #0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			65,377	65,377		65,377	2,614	67,991			30
31	Amortization of Pre-Op. & Org.							774	774			31
32	Interest			19,817	19,817		19,817	15,801	35,618			32
33	Real Estate Taxes			47,989	47,989		47,989	195	48,184			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			47,765	47,765		47,765	828	48,593			35
36	Other (specify):*											36
37	**TOTAL Ownership**			180,948	180,948		180,948	20,212	201,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,062		1,062		1,062		1,062			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,476	143,476		143,476		143,476			42
43	Other (specify):*		231	80,797	81,028		81,028	(81,028)				43
44	**TOTAL Special Cost Centers**		1,293	224,273	225,566		225,566	(81,028)	144,538			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,037,236	198,593	952,702	2,188,531		2,188,531	(44,820)	2,143,711			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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	(393)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,530)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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	(19,710)	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	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,338)	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	(6,688)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,693)		$	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)	44,873	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,873		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,820)		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

Aspen Rehab & Hlth Care Ctr

ID# 0053496

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Resident Flowers	$ (4)	43	1
2	Disallowed Special Events	58	43	2
3	Offset Transportation Revenue	(5,829)	11	3
4	Offset Miscellaneous Nursing Supplies Revenue	(135)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(128)	21	5
6	Disallowed Chamber of Commerce Dues	(650)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(6,688)		49

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	$ 2,439	$ 2,439	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	58	58	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	13	13	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	165	165	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	926	926	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	20	20	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	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		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,104	2,104	12
13	V								13
14	Total			$			$ 5,726	$ * 5,726	14

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	$ 117	$ 117	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	27,457	27,457	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,248	1,248	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	14	14	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	9	9	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,220	2,220	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	391	391	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,242	2,242	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,426	1,426	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	110	110	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	564	564	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			$			$ 35,798	$ * 35,798	39

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	63,600	63,600	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	138	138	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	1,464	1,464	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%	1,750	1,750	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	7,312	7,312	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			$			$ 74,264	$ * 74,264	39

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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 Management, Inc.	100.00%	$ 3,161	$ 3,161	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	7	7	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	22	22	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	46	46	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,180	1,180	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	15	15	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	200,400	Petersen Health Care Management, Inc.	100.00%	63,967	(136,433)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	4,752	4,752	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	38	38	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	34,689	34,689	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	11,967	11,967	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	11	11	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	13	13	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,180	1,180	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	99	99	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	152	152	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	202	202	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	85	85	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	264	264	38
39	Total			$ 200,400			$ 121,850	$ * (78,550)	39

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Wellness, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health & Wellness, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health & Wellness, LLC	100.00%	0		17
18	V	5	Utilities		Petersen Health & Wellness, LLC	100.00%	0		18
19	V	6	Maintenance		Petersen Health & Wellness, LLC	100.00%	0		19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		20
21	V	9	Medical Director		Petersen Health & Wellness, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health & Wellness, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health & Wellness, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health & Wellness, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health & Wellness, LLC	100.00%	0		26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health & Wellness, LLC	100.00%	0		27
28	V	21	Clerical and General Office		Petersen Health & Wellness, LLC	100.00%	0		28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health & Wellness, LLC	100.00%	0		29
30	V	23	Inservice Training & Education		Petersen Health & Wellness, LLC	100.00%	0		30
31	V	24	Travel and Seminar		Petersen Health & Wellness, LLC	100.00%	0		31
32	V	25	Other Admin. Staff Transport.		Petersen Health & Wellness, LLC	100.00%	0		32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health & Wellness, LLC	100.00%	0		33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		34
35	V	30	Depreciation		Petersen Health & Wellness, LLC	100.00%	0		35
36	V	31	Amortization of Pre-Op. & Org.		Petersen Health & Wellness, LLC	100.00%	774	774	36
37	V	32	Interest		Petersen Health & Wellness, LLC	100.00%	6,861	6,861	37
38	V	33	Real Estate Taxes		Petersen Health & Wellness, LLC	100.00%	0		38
39	Total			$			$ 7,635	$ * 7,635	39

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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											4
5											5
6	N/A										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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	1,572,338	77	$ 231,473	$ 220,289	16,568	$ 2,439	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	16,568	58	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	16,568	13	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	16,568	165	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	16,568	926	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	16,568	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	16,568	20	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	16,568	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	16,568	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	16,568	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	16,568	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	16,568	2,104	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	16,568	117	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	16,568	27,457	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	16,568	1,248	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	16,568	14	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	16,568	9	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	16,568	2,220	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	16,568	391	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	16,568	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	16,568	2,242	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	16,568	1,426	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	16,568	110	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	16,568	564	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 41,524	25

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	314,070	19	$	$	16,568	$	1
2	2	Food	Resident Days	314,070	19			16,568		2
3	3	Housekeeping	Resident Days	314,070	19			16,568		3
4	4	Laundry	Resident Days	314,070	19			16,568		4
5	5	Utilities	Resident Days	314,070	19			16,568		5
6	6	Maintenance	Resident Days	314,070	19			16,568		6
7	7	Mgmt. Allocation of Benefits	Resident Days	314,070	19			16,568		7
8	10	Nursing and Medical Records	Resident Days	314,070	19			16,568		8
9	12	Social Services	Resident Days	314,070	19			16,568		9
10	17	Administrative	Resident Days	314,070	19			16,568		10
11	19	Professional Services	Resident Days	314,070	19	1,618,178		16,568	63,600	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	314,070	19	3,514		16,568	138	12
13	21	Clerical and General Office	Resident Days	314,070	19			16,568		13
14	22	Employee Benefits & Payroll	Resident Days	314,070	19	37,245		16,568	1,464	14
15	23	Inservice Training & Education	Resident Days	314,070	19			16,568		15
16	24	Travel and Seminar	Resident Days	314,070	19			16,568		16
17	25	Other Admin. Staff Transport.	Resident Days	314,070	19			16,568		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	314,070	19			16,568		18
19	27	Mgmt. Allocation of Benefits	Resident Days	314,070	19			16,568		19
20	30	Depreciation	Resident Days	314,070	19	44,535		16,568	1,750	20
21	32	Interest	Resident Days	314,070	19	186,049		16,568	7,312	21
22	33	Real Estate Taxes	Resident Days	314,070	19			16,568		22
23	34	Rent-Facility and Grounds	Resident Days	314,070	19			16,568		23
24	35	Rent-Equipment & Vehicles	Resident Days	314,070	19			16,568		24
25	TOTALS					$ 1,889,521	$		$ 74,264	25

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Management, 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	1,572,338	77	$ 299,961	$ 294,997	16,568	$ 3,161	1
2	2	Food	Resident Days	1,572,338	77	675		16,568	7	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	16,568	22	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		16,568	46	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	16,568	1,180	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			16,568		6
7	9	Medical Director	Resident Days	1,572,338	77			16,568		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		16,568	15	8
9	10A	Therapy	Resident Days	1,572,338	77			16,568		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			16,568		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	16,568	63,967	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		16,568	4,752	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		16,568	38	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	16,568	34,689	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		16,568	11,967	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		16,568	11	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		16,568	13	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		16,568	1,180	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		16,568	99	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			16,568		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		16,568	152	21
22	32	Interest	Resident Days	1,572,338	77	19,133		16,568	202	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		16,568	85	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		16,568	264	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 121,850	25

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Wellness, 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	1,572,338	11	$	$	16,568	$	1
2	2	Food	Resident Days	1,572,338	11			16,568		2
3	3	Housekeeping	Resident Days	1,572,338	11			16,568		3
4	5	Utilities	Resident Days	1,572,338	11			16,568		4
5	6	Maintenance	Resident Days	1,572,338	11			16,568		5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			16,568		6
7	9	Medical Director	Resident Days	1,572,338	11			16,568		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	11			16,568		8
9	10A	Therapy	Resident Days	1,572,338	11			16,568		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			16,568		10
11	17	Administrative	Resident Days	1,572,338	11			16,568		11
12	19	Professional Services	Resident Days	1,572,338	11			16,568		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	11			16,568		13
14	21	Clerical and General Office	Resident Days	1,572,338	11			16,568		14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	11			16,568		15
16	23	Inservice Training & Education	Resident Days	1,572,338	11			16,568		16
17	24	Travel and Seminar	Resident Days	1,572,338	11			16,568		17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	11			16,568		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	11			16,568		19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	11			16,568		20
21	30	Depreciation	Resident Days	1,572,338	11			16,568		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	1,572,338	11	7,964		16,568	774	22
23	32	Interest	Resident Days	1,572,338	11	70,629		16,568	6,861	23
24	33	Real Estate Taxes	Resident Days	1,572,338	11			16,568		24
25	TOTALS					$ 78,593	$		$ 7,635	25

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Bank of America		X	Mortgage	Varies	1/17/07	$ 975,000	$ 401,437	12/31/14	0.0732	$ 19,817	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 975,000	$ 401,437			$ 19,817	9
	B. Non-Facility Related*											
10								Home Office Allocation-PHC			1,426	10
11								Home Office Allocation-PHO			7,312	11
12								Home Office Allocation-PHCM			202	12
13								Home Office Allocation-PHW			6,861	13
14	TOTAL Non-Facility Related						$	$			$ 15,801	14
15	TOTALS (line 9+line14)						$ 975,000	$ 401,437			$ 35,618	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 Aspen Rehab & Hlth Care Ctr **#** 0053496 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,336	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.)	2013	$ 47,449	2
3. Under or (over) accrual (line 2 minus line 1).		$ (887)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,876	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**		195	
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.		$ 48,184	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	44,994	8
	2010	46,651	9
	2011	46,758	10
	2012	46,924	11
	2013	47,449	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspen Rehab & Hlth Care Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0053496

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-100-14-00	Long-Term Care Facility	$ 47,449.24	$ 47,449.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,449.24	$ 47,449.24

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,656 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: 95,556
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 774
4. Dates Incurred: 2013-2014

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	261,360	2005	$ 36,000	1
2					2
3	TOTALS	261,360		$ 36,000	3

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	63		2005	1970	$ 959,500	$	25	$ 38,380	$ 38,380	$ 364,610	4
5			2005		15,000		15	1,000	1,000	9,500	5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks			2006	7,180		15	479	479	3,592	9
10	Duct Work			2006	584		20	29	29	218	10
11	Showers			2006	3,401		20	170	170	1,275	11
12	Subflooring			2006	5,450		20	273	273	2,047	12
13	Water Heater			2007	1,752		10	175	175	1,138	13
14	Ceramic Tile			2008	5,450		15	364	364	2,002	14
15	Showers			2008	6,075		25	243	243	1,338	15
16	Carpet for Building			2008	27,539		7	3,934	3,934	21,637	16
17	Sprinkler Head Installation			2009	3,816		15	254	254	1,143	17
18	Door Alarm Keypad			2011	2,972		10	298	298	745	18
19	Soffit Replacement & Repair to Water Damaged Kitchen Walls			2011	4,964		7	710	710	1,775	19
20	Kitchen Floor Tile Replacement			2011	6,150		7	878	878	2,195	20
21	Roof Replacement on West 100 Wing			2011	26,475		25	1,059	1,059	2,648	21
22	Water Heater			2012	3,814		7	544	544	816	22
23	Air Compressor			2013	5,393		7	770	770	1,155	23
24	Sprinkler Dry Vaccuum			2013	5,325		7	760	760	1,140	24
25	Sprinkler Head Replacement			2013	22,722		15	1,514	1,514	2,271	25
26	Kitchen & Shower Floor Tile Replacement			2013	14,451		15	964	964	1,446	26
27	Plumbing Repair-Resident Bathrooms			2013	8,035		7	1,148	1,148	1,722	27
28	Flooring Replacement-Kitchen, Bathroom, Shower Rooms			2013	42,610		15	2,840	2,840	4,260	28
29	Plumbing Repair-Resident Bathrooms			2014	6,544		7	935	935	935	29
30	Water Heater			2014	3,255		7	465	465	465	30
31	Water Softener			2014	4,206		7	451	451	451	31
32	Downspouts (10)			2014	3,830		15	192	192	192	32
33	Nurse Call Station System			2014	8,005		7	477	477	477	33
34	Garage/Storage Building			2014	12,735		15	354	354	354	34
35	Utility Room Flooring and Sink Replacement			2014	8,384		15	186	186	186	35
36	Siding for Exxisting Storage Shed			2014	6,800		15	113	113	113	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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Resident Room Floor Replacement in 29 Roor	2014	$ 39,791	$	15	$ 663	$ 663	$ 663	37
38	Concrete Slab for Garbage Dumpsters	2014	10,728		15	119	119	119	38
39	Sidewalk Replacement	2014	6,200		15	69	69	69	39
40	Kitchen Floor Rebuild and Replacement	2014	24,666		15	274	274	274	40
41	Mold Remediation in Bathrooms and Shower Install	2014	6,382		7	76	76	76	41
42	Shower Room Floor Repair	2014	4,224		7	50	50	50	42
43	Front Awning	2014	4,300		15	24	24	24	43
44	Dining Room Floor Replacement	2014	24,954		15				44
45	Ductwork Repair	2014	3,175		7				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	Land Improvements Booked			1,726			(1,726)		63
64	Building Booked			38,405			(38,405)		64
65	Building Improvement Booked			20,888			(20,888)		65
66									66
67	2014-Home Office Allocation-Building Improvements		7,734			185	185		67
68	2014-Home Office Allocation-Land Improvements		722			40	40		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,365,293	$ 61,019		$ 61,459	$ 440	$ 433,121	70

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 32,516	$ 4,057	$ 3,252	$ (805)	5-10 yrs.	$ 13,509	71
72	Current Year Purchases	14,644	301	301		7 yrs	301	72
73	Fully Depreciated Assets	193,214					193,214	73
74	Home Office Allocation			2,979	2,979			74
75	TOTALS	$ 240,374	$ 4,358	$ 6,532	$ 2,174		$ 207,024	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)	$ 1,641,667	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,377	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,991	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,614	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 640,145	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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 41,655 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	$ 578.00	$ 6,938	17
18					18
19					19
20					20
21	TOTAL		$ 578.00	$ 6,938	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.

Aspen Rehab & Hlth Care Ctr
0053496
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	2,137
Dishwasher		606
Laundry Equipment		59
Generator		29,809
Copier		8,216
Home Office Allocation		828
		41,655

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				27		27	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				1,062		1,062	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			$		$	$ 1,089		$ 1,089	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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ (266,419)	$ (266,419)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,159)	895,391	895,391	3
4	Supply Inventory (priced at)	7,870	7,870	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,916	22,916	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Expenses	6,981	6,981	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 666,739	$ 666,739	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,847	36,000	13
14	Buildings, at Historical Cost	959,500	982,234	14
15	Leasehold Improvements, at Historical Cost	369,706	383,059	15
16	Equipment, at Historical Cost	240,374	240,374	16
17	Accumulated Depreciation (book methods)	(639,278)	(640,145)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,004,149	$ 1,001,522	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,670,888	$ 1,668,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 441,434	$ 441,434	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,469	54,469	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,011	33,011	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,876	48,876	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	24,225	24,225	36
37	Accrued Management Fees	298,220	298,220	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 900,235	$ 900,235	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	401,437	401,437	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	4,423	4,423	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 405,860	$ 405,860	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,306,095	$ 1,306,095	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 364,793	$ 362,166	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,670,888	$ 1,668,261	48

***(See instructions.)**

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,048,976	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(8,276)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,040,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(34,874)	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)**	$ (34,874)	17
	B. Transfers (Itemize):		
18	**Transfer of Net Assets due to Corporate Restructuring**	(641,033)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (641,033)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 364,793	24 *

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

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 2,146,972	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,146,972	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	393	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 393	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	263	28
28a	Transportation Revenue	6,029	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,292	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,153,657	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	492,814	31
32	Health Care	832,637	32
33	General Administration	456,566	33
	B. Capital Expense		
34	Ownership	180,948	34
	C. Ancillary Expense		
35	Special Cost Centers	82,090	35
36	Provider Participation Fee	143,476	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,188,531	40
41	**Income before Income Taxes (line 30 minus line 40)****	(34,874)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (34,874)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,880,077	44
45	Private Pay - Net Inpatient Revenue	266,895	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,146,972	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 60,000	$ 28.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,735	2,937	67,175	22.87	3
4	Licensed Practical Nurses	12,560	13,138	214,692	16.34	4
5	CNAs & Orderlies	29,696	30,809	307,749	9.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,160	1,307	14,884	11.39	9
10	Activity Assistants	300	305	2,979	9.75	10
11	Social Service Workers	1,907	1,907	27,833	14.60	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,462	18.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,730	9,120	82,564	9.05	15
16	Dishwashers					16
17	Maintenance Workers	1,968	1,968	26,883	13.66	17
18	Housekeepers	6,307	6,648	58,923	8.86	18
19	Laundry	6,463	6,686	56,265	8.42	19
20	Administrator	1,938	2,010	63,967	31.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,623	1,719	21,451	12.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,080	2,080	58,376	28.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,627	84,795	$ 1,101,203 *	$ 12.99	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	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,514	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,514		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shelley Katzenburger	Administrator	0	$ 32,925
Lori Schlais	Administrator	0	31,042
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,967

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Mediacom	Computer Services	$ 1,617
E-Health Data Solutions	Computer Services	2,787
Illinois Sec of State	Filing Fees	360
Rock Island Circuit Clerk	Legal Services	136
Honkamp Kruger Co.	Accounting Fees	2,554
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 7,455

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,281
Unemployment Compensation Insurance	35,717
FICA Taxes	78,444
Employee Health Insurance	(4,252)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	897
Employee Retirement	560
Home Office Allocation	14,679
TOTAL (agree to Schedule V, line 22, col.8)	$ 159,326

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	1,888
Health Care Worker Background Check (Indicate # of checks performed 31)	
Patient Background Checks	316
Miscellaneous Licenses & Permits	525
Miscellaneous Dues & Subscriptions	1,249
Home Office Allocation	293
Less: Public Relations Expense	(650)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,611

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	22
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22

**See instructions.

Aspen Rehab & Hlth Care Ctr
0053496
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,455
Home Office Allocation		
Lexis Nexis	Legal	6
GoffWilson	Legal	386
Illinois Secretary of State	Legal	35
Bank of America	Legal	117
Healthcare Resources International	Legal	70
Miscellaneous	Legal	15
Addy, Bush	Legal	10
Hall, Rustom, and Fritz	Legal	12
Black, Hedin, Ballard	Legal	20
SmithAmundsen	Legal	21
CliftonLarson Allen	Accountants	822
Ginoli & Co.	Accountants	1,770
Miscellaneous	Computer Services	15
Odessian LLC	Computer Services	5
Optimizer	Computer Services	33
Allpayer Exchange	Computer Services	10
CCH	Computer Services	18
Prism Software	Computer Services	52
Macquarie Technology Services	Computer Services	46
Advanced Answers on Demand	Computer Services	2,434
Stratus Networks	Computer Services	320
Kemper Technology	Computer Services	950
AT&T	Computer Services	3
Ability Network	Computer Services	368
Barracuda	Computer Services	84

CIAN	Computer Services	100
Comcast	Computer Services	26
Emdeon	Computer Services	65
Charter Communications	Computer Services	4
Crawford County Title Co.	Other Prof Fees	5
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	28
All Scripts	Other Prof Fees	19
Miscellaneous	Other Prof Fees	1
Registered Agent Solutions	Other Prof Fees	12
MGBD	Other Prof Fees	62,571
Total (agree to Schedule V, line 19, column 8)		77,911

Facility Name & ID Number Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Aspen Rehab & Hlth Care Ctr # 0053496 Report Period Beginning: 1/1/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - 598.85**

(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. $ **18,221** 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. $ **143,476**
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. $ **393**

(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. $ **5,829**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adqequate 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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.