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: 0047415

Facility Name: Bloomington Rehab & HCC

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

County: McLean

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 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 Bloomington Rehab & HCC # 0047415 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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			872	872	8
9	SNF/PED					9
10	ICF	16,257	2,119	181	18,557	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,257	2,119	1,053	19,429	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.24%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 872

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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				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	97,829	11,828		109,657		109,657	6,567	116,224			1
2	Food Purchase		114,437		114,437		114,437	(170)	114,267			2
3	Housekeeping	76,939	27,253		104,192		104,192	41	104,233			3
4	Laundry	38,922	11,228		50,150		50,150		50,150			4
5	Heat and Other Utilities			57,507	57,507		57,507	247	57,754			5
6	Maintenance	42,059	9,675	16,231	67,965		67,965	2,468	70,433			6
7	Other (specify):* Home Off. Ben. All.											7
8	TOTAL General Services	255,749	174,421	73,738	503,908		503,908	9,153	513,061			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000	23	24,023			9
10	Nursing and Medical Records	862,376	88,764	9,650	960,790		960,790	1,935	962,725			10
10a	Therapy			207,846	207,846		207,846		207,846			10a
11	Activities	32,433	238	342	33,013		33,013	(2,612)	30,401			11
12	Social Services	31,164			31,164		31,164		31,164			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	925,973	89,002	241,838	1,256,813		1,256,813	(654)	1,256,159			16
	C. General Administration											
17	Administrative			244,600	244,600		244,600	(171,741)	72,859			17
18	Directors Fees											18
19	Professional Services			10,537	10,537		10,537	109,389	119,926			19
20	Dues, Fees, Subscriptions & Promotions			4,873	4,873		4,873	402	5,275			20
21	Clerical & General Office Expenses	39,119	3,982	11,672	54,773		54,773	72,818	127,591			21
22	Employee Benefits & Payroll Taxes			165,601	165,601		165,601	17,824	183,425			22
23	Inservice Training & Education			50	50		50	29	79			23
24	Travel and Seminar							25	25			24
25	Other Admin. Staff Transportation			9,336	9,336		9,336	3,987	13,323			25
26	Insurance-Prop.Liab.Malpractice			26,042	26,042		26,042	3,540	29,582			26
27	Other (specify):* Home Off. Ben. All.											27
28	TOTAL General Administration	39,119	3,982	472,711	515,812		515,812	36,273	552,085			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,220,841	267,405	788,287	2,276,533		2,276,533	44,772	2,321,305			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bloomington Rehab & HCC #0047415 Report Period Beginning: 1/1/14 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			27,755	27,755		27,755	15,871	43,626			30
31	Amortization of Pre-Op. & Org.							1,786	1,786			31
32	Interest			10,753	10,753		10,753	31,612	42,365			32
33	Real Estate Taxes			16,708	16,708		16,708	5,983	22,691			33
34	Rent-Facility & Grounds			56,866	56,866		56,866	(56,866)				34
35	Rent-Equipment & Vehicles			28,191	28,191		28,191	972	29,163			35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,273	140,273		140,273	(642)	139,631			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,927		32,927		32,927		32,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,924	168,924		168,924		168,924			42
43	Other (specify):*	30,000	351	172,642	202,993		202,993	(202,993)				43
44	**TOTAL Special Cost Centers**	30,000	33,278	341,566	404,844		404,844	(202,993)	201,851			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,250,841	300,683	1,270,126	2,821,650		2,821,650	(158,863)	2,662,787			45

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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	(246)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,381)	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	(622)	30		9
10	Interest and Other Investment Income	(1,077)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	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	(88,597)	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	(72,000)	43		24
25	Fund Raising, Advertising and Promotional	(33,335)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(3,413)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (205,693)		$	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)	46,830	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 46,830		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (158,863)		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**

Bloomington Rehab & HCC

ID# 0047415

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,714)	43	1
2	X-Rays-Part A	(1,117)	43	2
3	Special Events	173	43	3
4	Offset Miscellaneous Office Supplies Revenue	(59)	21	4
5	Offset Transportation Trans. Revenue	(2,612)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	1,916	10	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**	(3,413)		49

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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%	$ 2,860	$ 2,860	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	68	68	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	15	15	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	193	193	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	1,085	1,085	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	0		6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	23	23	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	157,000	Petersen Health Care, Inc.	100.00%	0	(157,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,467	2,467	12
13	V								13
14	Total			$ 157,000			$ 6,712	$ * (150,288)	14

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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%	$ 137	$ 137	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	32,198	32,198	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	1,464	1,464	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	16	16	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	10	10	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	2,604	2,604	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	459	459	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	0		22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,630	2,630	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,672	1,672	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	129	129	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	662	662	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			$			$ 41,981	$ * 41,981	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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%	101,100	101,100	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	220	220	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%	2,327	2,327	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%	2,782	2,782	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	11,624	11,624	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			$			$ 118,053	$ * 118,053	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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 Management, LLC		$ 3,707	$ 3,707	15
16	V	2	Food		Petersen Health Management, LLC		8	8	16
17	V	3	Housekeeping		Petersen Health Management, LLC		26	26	17
18	V	5	Utilities		Petersen Health Management, LLC		54	54	18
19	V	6	Maintenance		Petersen Health Management, LLC		1,383	1,383	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Management, LLC		0		20
21	V	9	Medical Director		Petersen Health Management, LLC		0		21
22	V	10	Nursing and Medical Records		Petersen Health Management, LLC		18	18	22
23	V	10A	Therapy		Petersen Health Management, LLC		0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Management, LLC		0		24
25	V	17	Administrative	87,600	Petersen Health Management, LLC		72,859	(14,741)	25
26	V	19	Professional Services		Petersen Health Management, LLC		5,572	5,572	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Management, LLC		45	45	27
28	V	21	Clerical and General Office		Petersen Health Management, LLC		40,679	40,679	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Management, LLC		14,033	14,033	29
30	V	23	Inservice Training & Education		Petersen Health Management, LLC		13	13	30
31	V	24	Travel and Seminar		Petersen Health Management, LLC		15	15	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Management, LLC		1,383	1,383	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Management, LLC		116	116	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Management, LLC		0		34
35	V	30	Depreciation		Petersen Health Management, LLC		178	178	35
36	V	32	Interest		Petersen Health Management, LLC		236	236	36
37	V	33	Real Estate Taxes		Petersen Health Management, LLC		100	100	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Management, LLC		310	310	38
39	Total			$ 87,600			$ 140,735	$ * 53,135	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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	19	Professional Services	$	Bloomington Land		$ 250	$ 250	15
16	V	26	Insurance-Property		Bloomington Land		2,965	2,965	16
17	V	30	Depreciation		Bloomington Land		10,903	10,903	17
18	V	31	Amortization		Bloomington Land		1,786	1,786	18
19	V	32	Interest		Bloomington Land		19,157	19,157	19
20	V	33	Real Estate Taxes		Bloomington Land		5,754	5,754	20
21	V	34	Rent-Income and Grounds	56,866	Bloomington Land			(56,866)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 56,866			$ 40,815	$ * (16,051)	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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 Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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	13,626	$ 2,860	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	13,626	68	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	13,626	15	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	13,626	193	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	13,626	1,085	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	13,626	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	13,626	23	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	13,626	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	13,626	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	13,626	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	13,626	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	13,626	2,467	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	13,626	137	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	13,626	32,198	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	13,626	1,464	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	13,626	16	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	13,626	10	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	13,626	2,604	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	13,626	459	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	13,626	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	13,626	2,630	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	13,626	1,672	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	13,626	129	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	13,626	662	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 48,693	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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	310,974	18	$	$	19,429	$	1
2	2	Food	Resident Days	310,974	18			19,429		2
3	3	Housekeeping	Resident Days	310,974	18			19,429		3
4	4	Laundry	Resident Days	310,974	18			19,429		4
5	5	Utilities	Resident Days	310,974	18			19,429		5
6	6	Maintenance	Resident Days	310,974	18			19,429		6
7	7	Mgmt. Allocation of Benefits	Resident Days	310,974	18			19,429		7
8	10	Nursing and Medical Records	Resident Days	310,974	18			19,429		8
9	12	Social Services	Resident Days	310,974	18			19,429		9
10	17	Administrative	Resident Days	310,974	18			19,429		10
11	19	Professional Services	Resident Days	310,974	18	1,618,180		19,429	101,100	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	310,974	18	3,515		19,429	220	12
13	21	Clerical and General Office	Resident Days	310,974	18			19,429		13
14	22	Employee Benefits & Payroll	Resident Days	310,974	18	37,246		19,429	2,327	14
15	23	Inservice Training & Education	Resident Days	310,974	18			19,429		15
16	24	Travel and Seminar	Resident Days	310,974	18			19,429		16
17	25	Other Admin. Staff Transport.	Resident Days	310,974	18			19,429		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	310,974	18			19,429		18
19	27	Mgmt. Allocation of Benefits	Resident Days	310,974	18			19,429		19
20	30	Depreciation	Resident Days	310,974	18	44,533		19,429	2,782	20
21	32	Interest	Resident Days	310,974	18	186,050		19,429	11,624	21
22	33	Real Estate Taxes	Resident Days	310,974	18			19,429		22
23	34	Rent-Facility and Grounds	Resident Days	310,974	18			19,429		23
24	35	Rent-Equipment & Vehicles	Resident Days	310,974	18			19,429		24
25	TOTALS					$ 1,889,524	$		$ 118,053	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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	13,626	$ 3,707	1
2	2	Food	Resident Days	1,572,338	77	675		13,626	8	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	13,626	26	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		13,626	54	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	13,626	1,383	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			13,626		6
7	9	Medical Director	Resident Days	1,572,338	77			13,626		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		13,626	18	8
9	10A	Therapy	Resident Days	1,572,338	77			13,626		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			13,626		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	13,626	72,859	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		13,626	5,572	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		13,626	45	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	13,626	40,679	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		13,626	14,033	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		13,626	13	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		13,626	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		13,626	1,383	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		13,626	116	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			13,626		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		13,626	178	21
22	32	Interest	Resident Days	1,572,338	77	19,133		13,626	236	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		13,626	100	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		13,626	310	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 140,735	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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	1/19/07	$ 2,019,400	$ 2,009,638	12/31/14	Varies	$ 29,910	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,019,400	$ 2,009,638			$ 29,910	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,077)	10
11								Home Office Allocation-PHCM			236	11
12								Home Office Allocation-PHC			1,672	12
13								Home Office Allocation-PHO			11,624	13
14	TOTAL Non-Facility Related						$	$			$ 12,455	14
15	TOTALS (line 9+line14)						$ 2,019,400	$ 2,009,638			$ 42,365	15

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

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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.**	$ 22,896	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	$ 22,342	2
3. Under or (over) accrual (line 2 minus line 1).		$ (554)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,016	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 229		
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,691	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	22,437	8
	2010	22,626	9
	2011	22,458	10
	2012	22,224	11
	2013	22,342	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 Bloomington Rehab & HCC COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 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.	21-16-128-012	Long-Term Care Facility	$ 22,341.90	$ 22,341.90
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,341.90	$ 22,341.90

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 Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 157,125 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 1,786 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	66,211	2005	$ 87,500	1
2					2
3	TOTALS	66,211		$ 87,500	3

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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	78		2005	1972	$ 528,930	$	30	$ 20,800	$ 20,800	$ 197,600	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvement			2005	13,000		15	867	867	8,236	9
10	Sign			2005	458		10	46	46	437	10
11	Sidewalks			2005	3,850		15	257	257	2,184	11
12	Roof			2007	9,076		20	454	454	3,632	12
13	Backflow			2008	9,779		25	392	392	2,548	13
14	Carpet			2008	6,911		7	988	988	6,422	14
15	Sprinkler Installation			2009	13,662		15	911	911	5,010	15
16	Water Service Line Repair			2009	5,990		7	856	856	4,708	16
17	Parking Lot Repair			2011	38,631		15	2,576	2,576	9,016	17
18	Sidewalk repair			2011	5,545		15	370	370	1,295	18
19	Sprinkler Work			2012	16,800		15	1,120	1,120	3,920	19
20	Water Leak Repair			2012	9,216		7	1,316	1,316	3,290	20
21	Roof Replacement			2013	60,115		25	2,405	2,405	3,607	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29	Land Improvements Booked					1,236			(1,236)		29
30	Building Booked					20,826			(20,826)		30
31	Building Improvement Booked					10,925			(10,925)		31
32											32
33	2014-Home Office Allocation-Building Improvements				9,070			218	218		33
34	2014-Home Office Allocation-Land Improvements				847			46	46		34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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			$	$		$	$	$	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)		$ 731,880	$ 32,987		$ 33,622	$ 635	$ 251,905	70

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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	$ 30,255	$ 4,019	$ 3,027	$ (992)	5-10 yrs.	$ 11,372	71
72	Current Year Purchases	12,659	1,651	1,651		10 yrs.	1,651	72
73	Fully Depreciated Assets	116,111					116,111	73
74	Home Office Allocation			5,326	5,326			74
75	TOTALS	$ 159,025	$ 5,670	$ 10,004	$ 4,334		$ 129,134	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)	$ 978,405	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,657	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,626	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,969	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 381,039	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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: $ 18,939 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250	$ 829	$ 10,224	17
18					18
19					19
20					20
21	TOTAL		$ 828.89	$ 10,224	21

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

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

Bloomington Rehab & HCC
0047415
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 11,908
Dishwasher	599
Laundry Equipment	59
Copier	5,401
Home Office Allocation	972
	18,939

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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 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	$	5,520	$ 82,801	$	5,520	$ 82,801	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,089	31,339		2,089	31,339	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,247	93,706		6,247	93,706	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				32,927		32,927	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			$	13,856	$ 207,846	$ 32,927	13,856	$ 240,773	14

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

STATE OF ILLINOIS

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 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	$ 675	$ 675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 131,541)	625,934	625,934	3
4	Supply Inventory (priced at Cost)	8,321	8,321	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,868	28,263	6
7	Other Prepaid Expenses		19,540	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Lease	2,496	2,496	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 665,294	$ 685,229	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		462,242	12
13	Land		87,500	13
14	Buildings, at Historical Cost		538,000	14
15	Leasehold Improvements, at Historical Cost		193,880	15
16	Equipment, at Historical Cost		159,025	16
17	Accumulated Depreciation (book methods)		(381,039)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		155,339	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)**	$	$ 1,214,947	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 665,294	$ 1,900,176	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,165,066	$ 1,165,316	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,923	63,923	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,912	32,912	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,016	32
33	Accrued Interest Payable		6,448	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	75,502	75,502	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,337,403	$ 1,367,117	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,009,638	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	832,316	741	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 832,316	$ 2,010,379	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,169,719	$ 3,377,496	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,504,425)	$ (1,477,320)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 665,294	$ 1,900,176	48

*(See instructions.)

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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**	$ (636,673)	1	
2	Restatements (describe):		2	
3			3	
4	**Prior Period Adjustment**	(4,636)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (641,309)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	84,116	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)**	$ 84,116	17	
	B. Transfers (Itemize):			
18	**Transferr of Net Assets to Land Company**	(947,232)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (947,232)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,504,425)	24	*

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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	$ 2,719,032	1
2	Discounts and Allowances for all Levels	(230,641)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,488,391	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	335,760	6
7	Oxygen	181	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 335,941	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	246	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,865	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,792	20
21	Other Medical Services	3,699	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,077	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,077	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	(1,857)	28
28a	Transportation Revenue	2,612	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 755	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,905,766	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	503,908	31
32	Health Care	1,256,813	32
33	General Administration	515,812	33
	B. Capital Expense		
34	Ownership	140,273	34
	C. Ancillary Expense		
35	Special Cost Centers	235,920	35
36	Provider Participation Fee	168,924	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,821,650	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,116	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,116	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,910,210	44
45	Private Pay - Net Inpatient Revenue	299,054	45
46	Medicare - Net Inpatient Revenue	290,605	46
47	Other-(specify)		47
48	Other-(specify) Charity Contractual Allowance	(11,478)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,488,391	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 Bloomington Rehab & HCC # 0047415 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	$ 72,806	$ 35.00	1
2	Assistant Director of Nursing	68	68	1,789	26.31	2
3	Registered Nurses	6,872	7,115	197,668	27.78	3
4	Licensed Practical Nurses	7,463	7,853	164,838	20.99	4
5	CNAs & Orderlies	34,558	35,649	386,400	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,775	1,856	19,315	10.41	10
11	Social Service Workers	1,977	2,176	31,164	14.32	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,033	24,633	12.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,768	7,974	73,196	9.18	15
16	Dishwashers					16
17	Maintenance Workers	1,896	2,098	42,059	20.05	17
18	Housekeepers	7,690	7,908	76,939	9.73	18
19	Laundry	3,443	3,754	38,922	10.37	19
20	Administrator	2,080	2,080	72,859	35.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,891	2,089	39,119	18.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	4,982	5,048	81,993	16.24	33
34	TOTAL (lines 1 - 33)	86,576	89,781	$ 1,323,700 *	$ 14.74	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	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,083	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)		$ 28,083		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	19	$ 606	L10, C3	50
51	Licensed Practical Nurses	65	1,792	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	84	$ 2,398		53

Bloomington Rehab & HCC
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Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,622	1,688	38,875	23.03
Transportation		1,280	1,280	13,118	10.25
Marketing		2,080	2,080	30,000	14.42
	TOTAL	4,982	5,048	81,993	

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Kindred	Administrator	0	$ 72,859
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,859

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 244,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 244,600

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 2,889
Frontier	Computer Services	726
Allscripts	Data Services	1,949
Honkamp Kruger	Accounting Fees	1,130
Sorling, Northrup	Legal Fees	3,843
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 10,537

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,205
Unemployment Compensation Insurance	36,107
FICA Taxes	90,912
Employee Health Insurance	(4,259)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,509
Employee Retirement	127
Home Office Allocation	17,824
TOTAL (agree to Schedule V, line 22, col.8)	$ 183,425

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 138	1,385
Miscellaneous Licenses & Permits	709
Miscellaneous Dues & Subscriptions	789
Home Office Allocation	402
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,275

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	25
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25

**See instructions.

Bloomington Rehab & HCC
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,537
Home Office Allocation-PHC, PHCM, & PHO		
Lexis Nexis	Legal	7
GoffWilson	Legal	453
Illinois Secretary of State	Legal	291
Bank of America	Legal	137
Healthcare Resources International	Legal	82
Miscellaneous	Legal	18
Addy, Bush	Legal	12
Hall, Rustom, and Fritz	Legal	14
Black, Hedin, Ballard	Legal	24
SmithAmundsen	Legal	24
CliftonLarson Allen	Accountants	963
Ginoli & Co.	Accountants	2,499
Miscellaneous	Computer Services	14
Odessian LLC	Computer Services	6
Optimizer	Computer Services	38
Allpayer Exchange	Computer Services	12
CCH	Computer Services	20
Prism Software	Computer Services	62
Macquarie Technology Services	Computer Services	54
Advanced Answers on Demand	Computer Services	2854
Stratus Networks	Computer Services	376
Kemper Technology	Computer Services	1113
AT&T	Computer Services	5
Ability Network	Computer Services	431
Barracuda	Computer Services	98

CIAN	Computer Services	117
Comcast	Computer Services	30
Emdeon	Computer Services	77
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	33
All Scripts	Other Prof Fees	23
Miscellaneous	Other Prof Fees	3
Registered Agent Solutions	Other Prof Fees	20
Marotta Gund Budd Durza	Other Prof Fees	99,465
Total (agree to Schedule V, line 19, column 8)		119,926

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 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 Bloomington Rehab & HCC # 0047415 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-$789**

(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. $ **21,286** 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. $ **168,924**
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. $ **246**

(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. $ **2,612**
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.