FOR BHF USE

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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: 0048447

Facility Name: Collinsville Rehab & Hlth CC

Address: 614 North Summit (Number) Collinsville (City) 62234 (Zip Code)

County: Madison

Telephone Number: (618) 344-8476 **Fax #** (618) 344-8483

HFS ID Number:

Date of Initial License for Current Owners: 07/25/2006

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 Collinsville Rehab & Hlth CC # 0048447 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	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	18,075	1,488	1,449	21,012	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,075	1,488	1,449	21,012	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.57%

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 7/25/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/25/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 100 and days of care provided 1,292

Medicare Intermediary Wisconsin Physicians Service

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 Collinsville Rehab & Hlth CC # 0048447 **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	126,204	12,779	480	139,463		139,463	7,102	146,565			1
2	Food Purchase		130,694		130,694		130,694	(1,558)	129,136			2
3	Housekeeping	96,084	35,327		131,411		131,411	44	131,455			3
4	Laundry	48,510	5,374		53,884		53,884	209	54,093			4
5	Heat and Other Utilities			72,658	72,658		72,658	1,232	73,890			5
6	Maintenance	36,843	12,251	11,799	60,893		60,893	1,659	62,552			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	307,641	196,425	84,937	589,003		589,003	8,688	597,691			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400	25	14,425			9
10	Nursing and Medical Records	938,132	133,125	5,475	1,076,732		1,076,732	790	1,077,522			10
10a	Therapy			224,696	224,696		224,696		224,696			10a
11	Activities	40,153	193	394	40,740		40,740	(4,156)	36,584			11
12	Social Services	35,594			35,594		35,594		35,594			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	1,013,879	133,318	244,965	1,392,162		1,392,162	(3,341)	1,388,821			16
	C. General Administration											
17	Administrative			127,300	127,300		127,300	(61,996)	65,304			17
18	Directors Fees											18
19	Professional Services			192,142	192,142		192,142	(123,230)	68,912			19
20	Dues, Fees, Subscriptions & Promotions			3,569	3,569		3,569	4,688	8,257			20
21	Clerical & General Office Expenses	29,577	2,516	13,284	45,377		45,377	78,798	124,175			21
22	Employee Benefits & Payroll Taxes			289,895	289,895		289,895	24,474	314,369			22
23	Inservice Training & Education							32	32			23
24	Travel and Seminar							28	28			24
25	Other Admin. Staff Transportation			4,700	4,700		4,700	4,312	9,012			25
26	Insurance-Prop.Liab.Malpractice			33,730	33,730		33,730	622	34,352			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	29,577	2,516	664,620	696,713		696,713	(72,272)	624,441			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,351,097	332,259	994,522	2,677,878		2,677,878	(66,925)	2,610,953			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 Collinsville Rehab & Hlth CC #0048447 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			85,495	85,495		85,495	15,226	100,721			30
31	Amortization of Pre-Op. & Org.							19,541	19,541			31
32	Interest			66,300	66,300		66,300	23,699	89,999			32
33	Real Estate Taxes			36,542	36,542		36,542	248	36,790			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,542	60,542		60,542	1,050	61,592			35
36	Other (specify):*											36
37	**TOTAL Ownership**			248,879	248,879		248,879	59,764	308,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,612		53,612		53,612		53,612			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,242	183,242		183,242		183,242			42
43	Other (specify):*		274	118,513	118,787		118,787	(118,787)				43
44	**TOTAL Special Cost Centers**		53,886	301,755	355,641		355,641	(118,787)	236,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,351,097	386,145	1,545,156	3,282,398		3,282,398	(125,948)	3,156,450			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 Collinsville Rehab & Hlth CC # 0048447 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	(1,641)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,740)	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	8,937	30		9
10	Interest and Other Investment Income	(61)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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	(23,239)	43		18
19	Entertainment				19
20	Contributions	(150)	43		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	(908)	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	(162,248)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (265,083)		$	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)	139,135	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 139,135		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,948)		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

Collinsville Rehab & Hlth CC

ID# 0048447

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (4,946)	43	1
2	X-Rays-Part A	(2,282)	43	2
3	Offset Transportation Revenue	(4,156)	11	3
4	Offset Miscellaneous Office Supplies Revenue	770	21	4
5	Disllowed Special Events	(622)	43	5
6	Resident Flower	(593)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(145)	10	7
8	Settlement on Pinson Case	(150,000)	19	8
9	Marketing Supplies	(274)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(162,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Collinsville Rehab & Hlth CC **#** 0048447 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	3,093	0	0	4,009	0	0	0	0	0	0	7,102	1
2	Food Purchase	(1,641)	74	0	0	9	0	0	0	0	0	0	(1,558)	2
3	Housekeeping	0	16	0	0	28	0	0	0	0	0	0	44	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	209	0	0	58	0	0	0	0	0	0	267	5
6	Maintenance	0	1,174	0	163	1,496	0	0	0	0	0	0	2,833	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,641)	4,566	0	163	5,600	0	0	0	0	0	0	8,688	8
	B. Health Care and Programs													
9	Medical Director	0	25	0	0	0	0	0	0	0	0	0	25	9
10	Nursing and Medical Records	(145)	1	0	0	19	0	0	0	0	0	0	(125)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,156)	0	0	0	0	0	0	0	0	0	0	(4,156)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,301)	26	0	0	19	0	0	0	0	0	0	(4,256)	16
	C. General Administration													
17	Administrative	0	0	0	0	(15,096)	0	0	0	0	0	0	(15,096)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(150,000)	2,668	0	18,076	6,026	0	0	0	0	0	0	(123,230)	19
20	Fees, Subscriptions & Promotions	0	0	149	4,491	48	0	0	0	0	0	0	4,688	20
21	Clerical & General Office Expenses	770	0	34,821	(46,771)	43,993	0	0	0	0	0	0	32,813	21
22	Employee Benefits & Payroll Taxes	0	0	1,583	7,714	15,177	0	0	0	0	0	0	24,474	22
23	Inservice Training & Education	0	0	18	0	14	0	0	0	0	0	0	32	23
24	Travel and Seminar	0	0	11	0	17	0	0	0	0	0	0	28	24
25	Other Admin. Staff Transportation	0	0	2,816	0	1,496	0	0	0	0	0	0	4,312	25
26	Insurance-Prop.Liab.Malpractice	0	0	496	0	126	0	0	0	0	0	0	622	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(149,230)	2,668	39,894	(16,490)	51,801	0	0	0	0	0	0	(71,357)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(155,172)	7,260	39,894	(16,327)	57,420	0	0	0	0	0	0	(66,925)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	8,937	0	2,844	3,252	193	0	0	0	0	0	0	15,226	30
31	Amortization of Pre-Op. & Org.	0	0	0	19,541	0	0	0	0	0	0	0	19,541	31
32	Interest	(61)	0	1,808	21,696	256	0	0	0	0	0	0	23,699	32
33	Real Estate Taxes	0	0	140	0	108	0	0	0	0	0	0	248	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	715	0	335	0	0	0	0	0	0	1,050	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,876	0	5,507	44,489	892	0	0	0	0	0	0	59,764	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(118,787)	0	0	0	0	0	0	0	0	0	0	(118,787)	43
44	**TOTAL Special Cost Centers**	(118,787)	0	0	0	0	0	0	0	0	0	0	(118,787)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(265,083)	7,260	45,401	28,162	58,312	0	0	0	0	0	0	(125,948)	45

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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%	$ 3,093	$ 3,093	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	74	74	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	16	16	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	209	209	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,174	1,174	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%	25	25	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%	2,668	2,668	12
13	V								13
14	Total			$			$ 7,260	$ * 7,260	14

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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%	$ 149	$ 149	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	34,821	34,821	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,583	1,583	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	18	18	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	11	11	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,816	2,816	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	496	496	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%	2,844	2,844	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,808	1,808	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	140	140	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	715	715	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			$			$ 45,401	$ * 45,401	39

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Enterprises, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Enterprises, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Enterprises, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Enterprises, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Enterprises, LLC	100.00%	163	163	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Enterprises, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Enterprises, LLC	100.00%	18,076	18,076	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	4,491	4,491	26
27	V	21	Clerical and General Office	46,900	Petersen Health Enterprises, LLC	100.00%	129	(46,771)	27
28	V	22	Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	7,714	7,714	28
29	V	23	Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Enterprises, LLC	100.00%	3,252	3,252	34
35	V	31	Amortization		Petersen Health Enterprises, LLC	100.00%	19,541	19,541	35
36	V	32	Interest		Petersen Health Enterprises, LLC	100.00%	21,696	21,696	36
37	V	34	Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38
39	Total			$ 46,900			$ 75,062	$ * 28,162	39

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Care Management, Inc.		$ 4,009	$ 4,009	15
16	V	2	Food		Petersen Health Care Management, Inc.		9	9	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.		28	28	17
18	V	5	Utilities		Petersen Health Care Management, Inc.		58	58	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.		1,496	1,496	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.		0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.		0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.		19	19	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.		0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.		0		24
25	V	17	Administrative	80,400	Petersen Health Care Management, Inc.		65,304	(15,096)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.		6,026	6,026	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.		48	48	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.		43,993	43,993	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.		15,177	15,177	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.		14	14	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.		17	17	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.		1,496	1,496	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.		126	126	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.		0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.		193	193	35
36	V	32	Interest		Petersen Health Care Management, Inc.		256	256	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.		108	108	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.		335	335	38
39	Total			$ 80,400			$ 138,712	$ * 58,312	39

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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	21,012	$ 3,093	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	21,012	74	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	21,012	16	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	21,012	209	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	21,012	1,174	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,012	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	21,012	25	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	21,012	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	21,012	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,012	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	21,012	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	21,012	2,668	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	21,012	149	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	21,012	34,821	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	21,012	1,583	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	21,012	18	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	21,012	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	21,012	2,816	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	21,012	496	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,012	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	21,012	2,844	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	21,012	1,808	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	21,012	140	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	21,012	715	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 52,661	25

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Enterprises, 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	63,504	4	$	$	21,012	$	1
2	2	Food	Resident Days	63,504	4			21,012		2
3	3	Housekeeping	Resident Days	63,504	4			21,012		3
4	4	Laundry	Resident Days	63,504	4			21,012		4
5	5	Utilities	Resident Days	63,504	4			21,012		5
6	6	Maintenance	Resident Days	63,504	4	493		21,012	163	6
7	7	Mgmt. Allocation of Benefits	Resident Days	63,504	4			21,012		7
8	10	Nursing and Medical Records	Resident Days	63,504	4			21,012		8
9	15	Mgmt. Allocation of Benefits	Resident Days	63,504	4			21,012		9
10	17	Administrative	Resident Days	63,504	4			21,012		10
11	19	Professional Services	Resident Days	63,504	4	54,630		21,012	18,076	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	63,504	4	13,573		21,012	4,491	12
13	21	Clerical and General Office	Resident Days	63,504	4	389		21,012	129	13
14	22	Employee Benefits & Payroll	Resident Days	63,504	4	23,314		21,012	7,714	14
15	23	Inservice Training & Education	Resident Days	63,504	4			21,012		15
16	24	Travel and Seminar	Resident Days	63,504	4			21,012		16
17	25	Other Admin. Staff Transport.	Resident Days	63,504	4			21,012		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	63,504	4			21,012		18
19	27	Mgmt. Allocation of Benefits	Resident Days	63,504	4			21,012		19
20	30	Depreciation	Resident Days	63,504	4	9,827		21,012	3,252	20
21	31	Amortization	Resident Days	63,504	4	59,059		21,012	19,541	21
22	32	Interest	Resident Days	63,504	4	65,571		21,012	21,696	22
23	34	Rent-Facility and Grounds	Resident Days	63,504	4			21,012		23
24	35	Rent-Equipment & Vehicles	Resident Days	63,504	4			21,012		24
25	TOTALS					$ 226,856	$		$ 75,062	25

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	21,012	$ 4,009	1
2	2	Food	Resident Days	1,572,338	77	675		21,012	9	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	21,012	28	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		21,012	58	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	21,012	1,496	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,012		6
7	9	Medical Director	Resident Days	1,572,338	77			21,012		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		21,012	19	8
9	10A	Therapy	Resident Days	1,572,338	77			21,012		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,012		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	21,012	65,304	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		21,012	6,026	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		21,012	48	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	21,012	43,993	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		21,012	15,177	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		21,012	14	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		21,012	17	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		21,012	1,496	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		21,012	126	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,012		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		21,012	193	21
22	32	Interest	Resident Days	1,572,338	77	19,133		21,012	256	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		21,012	108	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		21,012	335	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 138,712	25

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	First Bank		X	Mortgage	$10,014.67	6/22/12	$ 1,368,750	$ 988,273	6/22/15	6.0000	$ 66,300	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,014.67		$ 1,368,750	$ 988,273			$ 66,300	9
	B. Non-Facility Related*											
10								Interest Income Offset			(61)	10
11								Home Office Allocation-PHC			1,808	11
12								Home Office Allocation-PHCM			21,696	12
13								Home Office Allocation-PHE			256	13
14	TOTAL Non-Facility Related						$	$			$ 23,699	14
15	TOTALS (line 9+line14)						$ 1,368,750	$ 988,273			$ 89,999	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 Collinsville Rehab & Hlth CC # 0048447 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.**	$ 42,684	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	$ 42,543	2
3. Under or (over) accrual (line 2 minus line 1).		$ (141)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,824	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Refund on Taxes** 7,141 **Home Office Allocation** 248	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 36,790	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	48,404	8
	2010	49,194	9
	2011	48,517	10
	2012	41,442	11
	2013	42,543	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 Collinsville Rehab & Hlth CC COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0048447

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.	13-2-21-28-18-303-001	Long-Term Care Facility	$ 42,543.44	$ 42,543.44
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,543.44	$ 42,543.44

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 X _____ 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 Collinsville Rehab & Hlth CC # 0048447 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame Steel 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: 295,295
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 19,541
4. Dates Incurred: 2010-2012 Home Office Refinancing

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	391,343	2006	$ 40,000	1
2					2
3	TOTALS	391,343		$ 40,000	3

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	100		2006	1962	$ 1,635,299	$	30	$ 54,510	$ 54,510	$ 463,335	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair Ramp			2007	2,530		15	169	169	1,267	9
10	Fountain			2007	1,269		15	85	85	637	10
11	Exit Signs			2007	612		7	46	46	612	11
12	Blinds			2007	4,886		10	489	489	3,667	12
13	Exit Signs			2008	690		15	46	46	299	13
14	Boiler			2009	6,500		7	929	929	4,644	14
15	Sprinkler Repair			2009	22,880		7	3,268	3,268	17,974	15
16	Boiler			2010	11,339		15	756	756	5,914	16
17	A/C Unit			2010	6,260		15	418	418	1,881	17
18	Roof Replacement			2010	69,464		25	2,778	2,778	12,501	18
19	Nurse Call Light System			2011	6,260		10	626	626	2,191	19
20	Ceiling Repair			2011	2,575		7	368	368	1,288	20
21	Roof Replacement-Completion of 2010 Work			2011	44,923		25	1,796	1,796	6,286	21
22	Roof Repairs			2012	3,047		7	436	436	1,090	22
23	Roof and Gutter Replacement			2012	64,790		25	2,592	2,592	6,480	23
24	Roof Repairs			2013	9,793		7	1,400	1,400	2,100	24
25	Condensing Unit			2014	4,500		7	268	268	268	25
26	Roof Replacement			2014	48,950		25	653	653	653	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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 Collinsville Rehab & Hlth CC # 0048447 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	Land Improvements Booked			253			(253)		63
64	Building Booked			65,634			(65,634)		64
65	Building Improvement Booked			14,579			(14,579)		65
66									66
67	2014-Home Office Allocation-Building Improvements		9,809			235	235		67
68	2014-Home Office Allocation-Land Improvements		916			50	50		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,957,292	$ 80,466		$ 71,918	$ (8,548)	$ 533,087	70

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	$ 227,986	$ 5,029	$ 22,799	$ 17,770	5-10 yrs.	$ 182,125	71
72	Current Year Purchases	2,764						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,004	6,004			74
75	TOTALS	$ 230,750	$ 5,029	$ 28,803	$ 23,774		$ 182,125	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)	$ 2,228,042	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,495	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 100,721	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,226	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 715,212	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 Collinsville Rehab & Hlth CC # 0048447 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: $ 55,130 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	2009 Ford E150	$ 538.00	$ 6,462	17
18					18
19					19
20					20
21	TOTAL		$ 538.00	$ 6,462	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.

Collinsville Rehab & Hlth CC
0048447
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	$ 47,561
Dishwasher	718
Laundry equipment	-
Equipment	5,801
Home Office Allocation	1,050
	55,130

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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	$	6,618	$ 99,276	$	6,618	$ 99,276	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,121	31,809		2,121	31,809	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,241	93,611		6,241	93,611	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				53,612		53,612	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			$	14,980	$ 224,696	$ 53,612	14,980	$ 278,308	14

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	$ (763,460)	$ (763,460)	1
2	Cash-Patient Deposits	243	243	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 293,808)	1,083,060	1,083,060	3
4	Supply Inventory (priced at)	10,390	10,390	4
5	Short-Term Investments			5
6	Prepaid Insurance	36,104	36,104	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,000)	(1,000)	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 365,337	$ 365,337	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,645,108	14
15	Leasehold Improvements, at Historical Cost	233,186	312,184	15
16	Equipment, at Historical Cost	235,636	230,750	16
17	Accumulated Depreciation (book methods)	(830,783)	(715,212)	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)**	$ 1,317,137	$ 1,512,830	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,682,474	$ 1,878,167	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 890,888	$ 890,888	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,553	79,553	30
31	Accrued Taxes Payable (excluding real estate taxes)	91,602	91,602	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,824	43,824	32
33	Accrued Interest Payable	5,105	5,105	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,712	1,712	36
37	Accrued Management Fees	315,826	315,826	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,428,510	$ 1,428,510	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	988,273	988,273	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 988,273	$ 988,273	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,416,783	$ 2,416,783	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (734,309)	$ (538,616)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,682,474	$ 1,878,167	48

***(See instructions.)**

Facility Name & ID Number Collinsville Rehab & Hlth CC **#** 0048447 **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**	$ (748,316)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (748,316)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,007	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)**	$ 14,007	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (734,309)	24 *

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

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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	$ 3,006,897	1
2	Discounts and Allowances for all Levels	(238,281)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,768,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,401	6
7	Oxygen	1	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 402,402	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	1,641	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	95,592	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,279	20
21	Other Medical Services	15,283	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 121,795	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	61	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 61	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	(625)	28
28a	Transportation Revenue	4,156	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,531	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,296,405	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	589,003	31
32	Health Care	1,392,162	32
33	General Administration	696,713	33
	B. Capital Expense		
34	Ownership	248,879	34
	C. Ancillary Expense		
35	Special Cost Centers	172,399	35
36	Provider Participation Fee	183,242	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,282,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,007	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,007	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,257,435	44
45	Private Pay - Net Inpatient Revenue	298,112	45
46	Medicare - Net Inpatient Revenue	230,807	46
47	Other-(specify) Charity Therapy Allowance	(17,738)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,768,616	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 Collinsville Rehab & Hlth CC # 0048447 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	$ 48,960	$ 23.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,181	2,222	56,498	25.43	3
4	Licensed Practical Nurses	15,151	16,132	326,516	20.24	4
5	CNAs & Orderlies	42,127	43,246	450,274	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	1,912	21,333	11.16	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	35,594	17.11	11
12	Dietician					12
13	Food Service Supervisor	2,148	2,148	31,127	14.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,267	10,629	95,077	8.95	15
16	Dishwashers					16
17	Maintenance Workers	1,977	2,105	36,843	17.50	17
18	Housekeepers	9,727	9,920	96,084	9.69	18
19	Laundry	5,122	5,407	48,510	8.97	19
20	Administrator	1,820	1,995	65,304	32.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,012	2,087	29,577	14.17	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	3,886	3,902	74,704	19.15	33
34	TOTAL (lines 1 - 33)	102,385	105,863	$ 1,416,402 *	$ 13.38	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	8	$ 480	L1, C3	35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,463	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	165	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	12	$ 19,508		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Collinsville Rehab & Hlth CC
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Period Beginning **1/1/2014**
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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		2,080	2,080	55,884	26.87
Transportation		1,806	1,822	18,820	10.33
	TOTAL	3,886	3,902	74,704	

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tara Holmes	Administrator	0	$ 25,638
Shannon Moore	Administrator	0	39,666
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,304

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 127,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 127,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Midwest Litigation Services	Transcription Fees	$ 1,265
E-Health Data Solutions	Computer Services	1,480
Charter Communications	Computer Services	864
Brown & James	Legal Services	21,006
Sorling, Northrup, Hanna	Legal Services	2,577
Honkamp Krueger & Co.	Accounting Fees	3,350
Marge Groom	Consulting Fees	11,600
Liticia Pinson, CMS, Florine Pinson	Legal Settlement	150,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 192,142

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,978
Unemployment Compensation Insurance	58,875
FICA Taxes	100,746
Employee Health Insurance	(2,898)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,893
Employee Retirement	301
Home Office Allocation	24,474
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,369

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	$ 525
Advertising: Employee Recruitment	1,523
Health Care Worker Background Check	1,521
(Indicate # of checks performed)	
Patient Background Checks	
Miscellaneous Licenses & Permits	
Miscellaneous Dues & Subscriptions	
Home Office Allocation	4,688
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,257

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28

**See instructions.

Collinsville Rehab & Hlth CC
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Period Beginning **1/1/2014**
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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)		192,142
Home Office Allocation-PHC, PHCM, & PHE		
Lexis Nexis	Legal	7
GoffWilson	Legal	489
Illinois Secretary of State	Legal	44
Bank of America	Legal	148
Healthcare Resources International	Legal	89
Miscellaneous	Legal	19
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	15
Black, Hedin, Ballard	Legal	26
SmithAmundsen	Legal	26
Beerman, Pritikin, Mirabelli, Swerdlove	Legal	1,047
CliftonLarson Allen	Accountants	3,523
Ginoli & Co.	Accountants	5,018
Miscellaneous	Computer Services	20
Odessian LLC	Computer Services	6
Optimizer	Computer Services	41
Allpayer Exchange	Computer Services	13
CCH	Computer Services	22
Prism Software	Computer Services	66
Macquarie Technology Services	Computer Services	58
Advanced Answers on Demand	Computer Services	3,087
Stratus Networks	Computer Services	406
Kemper Technology	Computer Services	1,204
AT&T	Computer Services	5
Ability Network	Computer Services	467

Barracuda	Computer Services	106
CIAN	Computer Services	127
Comcast	Computer Services	32
Emdeon	Computer Services	82
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	4
David Budde	Other Prof Fees	36
All Scripts	Other Prof Fees	24
Miscellaneous	Other Prof Fees	6
Marotta, Gund, Budd, Derza	Other Prof Fees	10,484
Total (agree to Schedule V, line 19, column 8)		218,913

Collinsville Rehab & Hlth CC
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Period Beginning **1/1/2014**
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Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC, PHCM, PHE		
Lexis Nexis	Legal	7
GoffWilson	Legal	489
Illinois Secretary of State	Legal	44
Bank of America	Legal	148
Healthcare Resources International	Legal	89
Miscellaneous	Legal	19
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	15
Black, Hedin, Ballard	Legal	26
SmithAmundsen	Legal	26
Beerman, Pritikin, Mirabelli, Swerdlove	Legal	1,047
Direct Facility Invoices		
Midwest Litigation Services-Transcription Fees	1/30/2014	1,265
Marge Groom-Consulting Fees on Pinson Case	2/11/2014	11,600
Brown & James-Legal Fees on Pinson Case	1/21/2014	20,653
Brown & James-Legal Fees on Pinson Case	4/10/2014	353
Sorling, Northrup-Legal Fees on Pinson Case	9/9/2014	1,886
Sorling, Northrup-Legal Fees on Pinson Case	10/8/2014	690
Liticia Pinson, CMS, Estate of Florine Pinson-Settlement	3/28 and 10/3/2014	150,000
Non-Allowable Settlement		(150,000)
Total Legal Fees		38,370

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 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 Collinsville Rehab & Hlth CC # 0048447 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? **No**
If YES, give association name and amount. **N/A**

(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. $ **24,762** 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. $ **183,242**
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. $ **1,641**

(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. $
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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.