

		FOR BHF USE				

LL1

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.

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

I. IDPH License ID Number: 0052647

Facility Name: Polo Rehabilitation & HCC

Address: 703 East Buffalo Polo 61064
 Number City Zip Code

County: Ogle

Telephone Number: (815) 956-2203 **Fax #** (815) 946-2895

HFS ID Number: _____

Date of Initial License for Current Owners: 2/1/08

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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) <u>Mark B. Petersen</u>	
	(Title) <u>Chief Executive Officer</u>	
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 Polo Rehabilitation & HCC

0052647 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	81	Skilled (SNF)	81	29,565	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	81	TOTALS	81	29,565	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,562	5,106	1,332	19,000	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,562	5,106	1,332	19,000	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.27%

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 NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 2/1/08

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2/1/08 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 81 and days of care provided 1,167

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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

Polo Rehabilitation & HCC

0052647

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	163,833	15,682		179,515		179,515	6,422	185,937		1
2	Food Purchase		137,976		137,976		137,976	(6,849)	131,127		2
3	Housekeeping	100,427	31,879		132,306		132,306	39	132,345		3
4	Laundry	17,137	7,667		24,804		24,804		24,804		4
5	Heat and Other Utilities			96,524	96,524		96,524	242	96,766		5
6	Maintenance	47,155	13,016	23,717	83,888		83,888	2,414	86,302		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	328,552	206,220	120,241	655,013		655,013	2,268	657,281		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400	23	20,423		9
10	Nursing and Medical Records	868,127	58,927	7,047	934,101		934,101	(182)	933,919		10
10a	Therapy			137,592	137,592		137,592		137,592		10a
11	Activities	39,263	721	534	40,518		40,518	(5,047)	40,518		11
12	Social Services	27,580			27,580		27,580		27,580		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	934,970	59,648	165,573	1,160,191		1,160,191	(5,206)	1,160,032		16
	C. General Administration										
17	Administrative			227,600	227,600		227,600	(162,908)	64,692		17
18	Directors Fees										18
19	Professional Services			5,451	5,451		5,451	20,126	25,577		19
20	Dues, Fees, Subscriptions & Promotions			8,050	8,050		8,050	3,328	11,378		20
21	Clerical & General Office Expenses	26,327	4,443	10,944	41,714		41,714	71,356	113,070		21
22	Employee Benefits & Payroll Taxes			212,262	212,262		212,262	16,279	228,541		22
23	Inservice Training & Education							29	29		23
24	Travel and Seminar							25	25		24
25	Other Admin. Staff Transportation			8,002	8,002		8,002	3,899	11,901		25
26	Insurance-Prop.Liab.Malpractice			28,057	28,057		28,057	563	28,620		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	26,327	4,443	500,366	531,136		531,136	(47,303)	483,833		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,289,849	270,311	786,180	2,346,340		2,346,340	(50,241)	2,301,146		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

Polo Rehabilitation & HCC

#0052647

Report Period Beginning:

1/1/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			100,914	100,914		100,914	(30,953)	69,961			30
31	Amortization of Pre-Op. & Org.							5,604	5,604			31
32	Interest			95,809	95,809		95,809	21,127	116,936			32
33	Real Estate Taxes			36,275	36,275		36,275	224	36,499			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,248	22,248		22,248	950	23,198			35
36	Other (specify):*											36
37	TOTAL Ownership			255,246	255,246		255,246	(3,048)	252,198			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,528		49,528		49,528		49,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,919	159,919		159,919		159,919			42
43	Other (specify):*	20,654	1,333	45,461	67,448		67,448	(67,448)				43
44	TOTAL Special Cost Centers	20,654	50,861	205,380	276,895		276,895	(67,448)	209,447			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,310,503	321,172	1,246,806	2,878,481		2,878,481	(120,737)	2,762,791			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,924)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,147)	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	(34,387)	30		9
10	Interest and Other Investment Income	(2,321)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(557)	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	(24,130)	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		43		24
25	Fund Raising, Advertising and Promotional	(1,316)	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 <u>See Page 5A</u>	(33,883)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,665)		\$	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	2	
		Amount	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)	(4,072)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,072)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (120,737)		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	2	3	4	
		Yes	No	Amount	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

Polo Rehabilitation & HCC

ID# 0052647

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

	Amount	Reference	Sch. V Line
1 Labs-Part A	\$ (4,073)	43	1
2 X-Rays-Part A	(1,258)	43	2
3 Disallowed Special Events	494	43	3
4 Offset Miscellaneous Office Supplies Revenue	(58)	21	4
5 Offset Transportation Revenue	(5,047)	11	5
6 Pet Expense	(1,474)	43	6
7 Disallowed Chamber of Commerce Dues	(279)	20	7
8 Offset Nursing Supply Revenue	(201)	10	8
9 Disallowed Marketing Expense	(21,987)	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	(33,883)		49

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	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1	\$	Petersen Health Care, Inc.	100.00%	\$ 2,797	\$ 2,797	1	
2	V	2		Petersen Health Care, Inc.	100.00%	67	67	2	
3	V	3		Petersen Health Care, Inc.	100.00%	14	14	3	
4	V	5		Petersen Health Care, Inc.	100.00%	189	189	4	
5	V	6		Petersen Health Care, Inc.	100.00%	1,061	1,061	5	
6	V	7		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9		Petersen Health Care, Inc.	100.00%	23	23	7	
8	V	10		Petersen Health Care, Inc.	100.00%	1	1	8	
9	V	10A		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15		Petersen Health Care, Inc.	100.00%	0		10	
11	V	17		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19		Petersen Health Care, Inc.	100.00%	2,412	2,412	12	
13	V							13	
14	Total		\$			\$ 6,564	\$ *	6,564	14

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

Facility Name & ID Number Polo Rehabilitation & HCC# 0052647Report Period Beginning: 1/1/14Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 134	\$	134	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,487		31,487	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,432		1,432	17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	16		16	18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	10		10	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,546		2,546	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	449		449	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%	2,571		2,571	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,635		1,635	24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	126		126	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	647		647	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		\$			\$ 41,053	\$ *	41,053	39

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

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

Report Period Beginning:

1/1/14

Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Network, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0	
18	V	5 Utilities		Petersen Health Network, LLC	100.00%	0	
19	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0	
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	
21	V	9 Medical Director		Petersen Health Network, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0	
23	V	10A Therapy		Petersen Health Network, LLC	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	
25	V	17 Administrative		Petersen Health Network, LLC	100.00%	0	
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	11,090	11,090
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	808	808
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	146	146
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%	1,124	1,124
30	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0	
31	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0	
32	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0	
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0	
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	
35	V	30 Depreciation		Petersen Health Network, LLC	100.00%	375	375
36	V	31 Amortization of Pre-Op. & Org.		Petersen Health Network, LLC	100.00%	5,604	5,604
37	V	32 Interest		Petersen Health Network, LLC	100.00%	13,418	13,418
38	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0	
39	Total		\$			\$ 32,565	\$ * 32,565

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

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

Report Period Beginning:

1/1/14

Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care V, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Care V, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Care V, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Care V, LLC	100.00%	0	
19	V	5 Utilities		Petersen Health Care V, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Care V, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care V, LLC	100.00%	0	
23	V	10A Therapy		Petersen Health Care V, LLC	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0	
25	V	17 Administrative		Petersen Health Care V, LLC	100.00%	0	
26	V	19 Professional Services		Petersen Health Care V, LLC	100.00%	1,175	1,175
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care V, LLC	100.00%	2,621	2,621
28	V	21 Clerical and General Office		Petersen Health Care V, LLC	100.00%	0	
29	V	23 Inservice Training & Education		Petersen Health Care V, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Care V, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care V, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care V, LLC	100.00%	0	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0	
34	V	30 Depreciation		Petersen Health Care V, LLC	100.00%	314	314
35	V	31 Amortization		Petersen Health Care V, LLC	100.00%	0	
36	V	32 Interest		Petersen Health Care V, LLC	100.00%	8,164	8,164
37	V	34 Rent-Facility and Grounds		Petersen Health Care V, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care V, LLC	100.00%	0	
39	Total		\$			\$ 12,274	\$ * 12,274

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

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

Report Period Beginning:

1/1/14

Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,625	\$ 3,625
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	8	8
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	25	25
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	53	53
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,353	1,353
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	18	18
23	V	10A TherUy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	227,600	Petersen Health Care Management, Inc.	100.00%	64,692	(162,908)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	5,449	5,449
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	44	44
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,781	39,781
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,723	13,723
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	13	13
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,353	1,353
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	114	114
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	174	174
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	231	231
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	98	98
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	303	303
39	Total		\$ 227,600			\$ 131,072	\$ * (96,528)

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

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

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, I	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 System	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	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	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

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

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

Polo Rehabilitation & HCC

#

0052647

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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

Polo Rehabilitation & HCC

0052647

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,572,338	77	\$ 231,473	\$ 220,289	19,000	\$ 2,797	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	19,000	67	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	19,000	14	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	19,000	189	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	19,000	1,061	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	19,000	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	19,000	23	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	19,000	1	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	19,000	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	19,000	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	19,000	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	19,000	2,412	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	19,000	134	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	19,000	31,487	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	19,000	1,432	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	19,000	16	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	19,000	10	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	19,000	2,546	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	19,000	449	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	19,000	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	19,000	2,571	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	19,000	1,635	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	19,000	126	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	19,000	647	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 47,617	25

Facility Name & ID Number Polo Rehabilitation & HCC

0052647

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 Petersen Health Network, 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	247,554	14	\$	\$	19,000	\$	1
2	2	Food	Resident Days	247,554	14			19,000		2
3	3	Housekeeping	Resident Days	247,554	14			19,000		3
4	5	Utilities	Resident Days	247,554	14			19,000		4
5	6	Maintenance	Resident Days	247,554	14			19,000		5
6	7	Mgmt. Allocation of Benefits	Resident Days	247,554	14			19,000		6
7	9	Medical Director	Resident Days	247,554	14			19,000		7
8	10	Nursing and Medical Records	Resident Days	247,554	14			19,000		8
9	10A	Therapy	Resident Days	247,554	14			19,000		9
10	15	Mgmt. Allocation of Benefits	Resident Days	247,554	14			19,000		10
11	17	Administrative	Resident Days	247,554	14			19,000		11
12	19	Professional Services	Resident Days	247,554	14	192,241		19,000	11,090	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	247,554	14	14,000		19,000	808	13
14	21	Clerical and General Office	Resident Days	247,554	14	2,534		19,000	146	14
15	22	Employee Benefits and Payroll Tax	Resident Days	247,554	14	19,477		19,000	1,124	15
16	23	Inservice Training & Education	Resident Days	247,554	14			19,000		16
17	24	Travel and Seminar	Resident Days	247,554	14			19,000		17
18	25	Other Admin. Staff Transport.	Resident Days	247,554	14			19,000		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	247,554	14			19,000		19
20	27	Mgmt. Allocation of Benefits	Resident Days	247,554	14			19,000		20
21	30	Depreciation	Resident Days	247,554	14	6,500		19,000	375	21
22	31	Amortization of Pre-Op. & Org.	Resident Days	247,554	14	97,144		19,000	5,604	22
23	32	Interest	Resident Days	247,554	14	232,596		19,000	13,418	23
24	33	Real Estate Taxes	Resident Days	247,554	14			19,000		24
25	TOTALS					\$ 564,492	\$		\$ 32,565	25

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

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

Petersen Health Care V, 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	16,881	77	\$ 299,961	\$ 19,000	\$	1
2	2	Food	Resident Days	16,881	77	675	19,000		2
3	3	Housekeeping	Resident Days	16,881	77	2,074	19,000		3
4	4	Laundry	Resident Days	16,881	77		19,000		4
5	5	Utilities	Resident Days	16,881	77	4,349	19,000		5
6	6	Maintenance	Resident Days	16,881	77	111,954	19,000		6
7	7	Mgmt. Allocation of Benefits	Resident Days	16,881	77		19,000		7
8	10	Nursing and Medical Records	Resident Days	16,881	77	1,457	19,000		8
9	10A	Therapy	Resident Days	16,881	77		19,000		9
10	15	Mgmt. Allocation of Benefits	Resident Days	16,881	77		19,000		10
11	17	Administrative	Resident Days	16,881	77		19,000		11
12	19	Professional Services	Resident Days	16,881	77	4,576,674	19,000	1,175	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	16,881	77	9,375	19,000	2,621	13
14	21	Clerical and General Office	Resident Days	16,881	77	450,944	19,000		14
15	23	Inservice Training & Education	Resident Days	16,881	77	3,292,039	19,000		15
16	24	Travel and Seminar	Resident Days	16,881	77	1,135,672	19,000		16
17	25	Other Admin. Staff Transport.	Resident Days	16,881	77	1,074	19,000		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	16,881	77	1,245	19,000		18
19	27	Mgmt. Allocation of Benefits	Resident Days	16,881	77	111,953	19,000		19
20	30	Depreciation	Resident Days	16,881	77	1,125	19,000	314	20
21	31	Amortization	Resident Days	16,881	77		19,000		21
22	32	Interest	Resident Days	16,881	77	14,419	19,000	8,164	22
23	34	Rent-Facility and Grounds	Resident Days	16,881	77	19,133	19,000		23
24	35	Rent-Equipment & Vehicles	Resident Days	16,881	77	8,076	19,000		24
25	TOTALS					\$ 10,042,199	\$	\$ 12,274	25

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,572,338	77	\$ 231,473	\$ 294,997	19,000	\$ 3,625	1
2	2	Food	Resident Days	1,572,338	77	5,537		19,000	8	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	558	19,000	25	3
4	5	Utilities	Resident Days	1,572,338	77	15,618		19,000	53	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	94,000	19,000	1,353	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			19,000		6
7	9	Medical Director	Resident Days	1,572,338	77	1,878		19,000		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71		19,000	18	8
9	10A	TherUy	Resident Days	1,572,338	77			19,000		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			19,000		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	19,000	64,692	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631		19,000	5,449	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115		19,000	44	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	3,146,898	19,000	39,781	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476		19,000	13,723	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316		19,000	13	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811		19,000	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720		19,000	1,353	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141		19,000	114	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			19,000		20
21	30	Depreciation	Resident Days	1,572,338	77	212,800		19,000	174	21
22	32	Interest	Resident Days	1,572,338	77	135,328		19,000	231	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451		19,000	98	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540		19,000	303	24
25	TOTALS					\$ 8,517,291	\$ 8,113,127		\$ 131,072	25

Facility Name & ID Number

Polo Rehabilitation & HCC

0052647

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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		The Private Bank		X	Mortgage	Varies	4/15/08	\$ 2,310,924	\$ 2,241,597	4/15/14	0.0404	\$ 95,809	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8										Interest Income Offset		(2,321)	8						
9		TOTAL Facility Related						\$ 2,310,924	\$ 2,241,597			\$ 93,488	9						
		B. Non-Facility Related*																	
10										Home Office Allocation-PHMC		231	10						
11										Home Office Allocation-PHCV		8,164	11						
12										Home Office Allocation-PHC		1,635	12						
13										Home Office Allocation-PHN		13,418	13						
14		TOTAL Non-Facility Related						\$	\$			\$ 23,448	14						
15		TOTALS (line 9+line14)						\$ 2,310,924	\$ 2,241,597			\$ 116,936	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2013 report.			\$	35,760	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	\$	35,483	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(277)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,552	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.)			\$	224	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	36,499	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	34,774	8	FOR BHF USE ONLY	
	2010	35,072	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	34,867	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	34,720	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	35,483	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Accrual based on prior year tax bill.					

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Polo Rehabilitation & HCC COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0052647

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-15-151-004</u>	<u>Long-Term Care Facility</u>	\$ <u>35,483.06</u>	\$ <u>35,483.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>35,483.06</u></u>	\$ <u><u>35,483.06</u></u>

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 Polo Rehabilitation & HCC

0052647

Report Period Beginning:

1/1/14

Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,456 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 5,604 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>160,032</u>	<u>2008</u>	<u>\$ 156,372</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	160,032		\$ 156,372	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	81		2008	1972	\$ 1,151,846	\$	39	\$ 29,534	\$ 29,534	\$ 191,971	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System		2010	2010	98,590		20	4,930	4,930	17,255	9
10	Water Heater		2010	2010	9,624		10	962	962	4,329	10
11	Plug and Pull Sprinkler Heads		2011	2011	2,677		7	382	382	1,337	11
12	Sprinkler System Repair		2011	2011	3,000		5	600	600	1,882	12
13	Patio		2011	2011	3,750		15	250	250	875	13
14	Condensing Unit		2011	2011	19,342		15	1,290	1,290	4,515	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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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							63
64	Building Booked				46,074		(46,074)	64
65	Building Improvement Booked				8,414		(8,414)	65
66								66
67	2014-Home Office Allocation-Building Improvements		8,869			213	213	67
68	2014-Home Office Allocation-Land Improvements		828			45	45	68
69								69
70	TOTAL (lines 4 thru 69)		\$ 1,298,526		\$ 54,488	\$ 38,206	\$ (16,282)	\$ 222,164 70

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

Facility Name & ID Number Polo Rehabilitation & HCC

0052647

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	\$ 285,787	\$ 7,368	\$ 28,579	\$ 21,211	5-10 yrs.	\$ 177,267	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,176	3,176			74
75	TOTALS	\$ 285,787	\$ 7,368	\$ 31,755	\$ 24,387		\$ 177,267	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,740,685	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,856	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,961	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,105	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 399,431	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	2010 Van	\$ 28,000	\$ 4,667	\$ 22,400	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 28,000	\$ 4,667	\$ 22,400	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.

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: _____*

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: \$ 23,198

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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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 \$ _____

* 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.

Polo Rehabilitation & HCC

0052647

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	\$	13,427
Dishwasher		-
Laundry Equipment		-
Copier		8,821
Home Office Allocation		950
		<u>23,198</u>
		<u><u>23,198</u></u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,779	\$ 56,683			\$	3,779	\$ 56,683	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		379	5,685				379	5,685	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs		5,015	75,224				5,015	75,224	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 prescripts					49,528			49,528	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			\$	9,173	\$ 137,592		\$ 49,528		9,173	\$ 187,120	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 **Polo Rehabilitation & HCC**# **0052647**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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,881,046	\$ 2,881,046	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,576)	605,016	605,016	3
4	Supply Inventory (priced at Cost)	8,974	8,974	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,332	29,332	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(289)	(289)	8
9	Other(specify): Security Deposits	11,966	11,966	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,536,045	\$ 3,536,045	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	156,372	156,372	13
14	Buildings, at Historical Cost	1,151,846	1,160,715	14
15	Leasehold Improvements, at Historical Cost	136,983	137,811	15
16	Equipment, at Historical Cost	313,787	313,787	16
17	Accumulated Depreciation (book methods)	(644,873)	(399,431)	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 (spe A/R Prior Owner)			22
23	Other(specify): Non-Care Assets			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,114,115	\$ 1,369,254	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,650,160	\$ 4,905,299	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 319,183	\$ 319,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,310	76,310	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,759	15,759	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,552	36,552	32
33	Accrued Interest Payable	8,989	8,989	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	44,776	44,776	36
37	Accrued Management Fees	155,809	155,809	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 657,378	\$ 657,378	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,241,597	2,241,597	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To From	(1,813)	(1,813)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,239,784	\$ 2,239,784	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,897,162	\$ 2,897,162	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,752,998	\$ 2,008,137	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,650,160	\$ 4,905,299	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,588,677	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,588,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,319	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)	\$ 164,319	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,752,998	24 *

* This must agree with page 17, line 47.

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,909,498	1
2	Discounts and Allowances for all Levels	(235,840)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,673,658	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,764	6
7	Oxygen	694	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 241,458	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	6,924	14
15	Telephone, Television and Radio	5,910	15
16	Rental of Facility Space		16
17	Sale of Drugs	89,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,268	20
21	Other Medical Services	9,811	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 120,057	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	259	28
28a	<u>Transportation Revenue</u>	5,047	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,306	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,042,800	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	655,013	31
32	Health Care	1,160,191	32
33	General Administration	531,136	33
B. Capital Expense			
34	Ownership	255,246	34
C. Ancillary Expense			
35	Special Cost Centers	116,976	35
36	Provider Participation Fee	159,919	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,878,481	40
41	Income before Income Taxes (line 30 minus line 40)**	164,319	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 164,319	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,636,558	44
45	Private Pay - Net Inpatient Revenue	837,940	45
46	Medicare - Net Inpatient Revenue	202,423	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(3,263)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,673,658	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 Polo Rehabilitation & HCC

0052647

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 72,016	\$ 34.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,128	4,241	111,387	26.26	3
4	Licensed Practical Nurses	11,202	11,526	258,298	22.41	4
5	CNAs & Orderlies	33,114	34,355	359,860	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,853	1,967	26,388	13.41	9
10	Activity Assistants	1,179	1,222	10,483	8.58	10
11	Social Service Workers	1,826	1,855	27,580	14.87	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	45,650	21.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,059	12,790	118,183	9.24	15
16	Dishwashers					16
17	Maintenance Workers	1,876	2,084	47,155	22.63	17
18	Housekeepers	9,789	10,116	100,427	9.93	18
19	Laundry	1,559	1,809	17,137	9.47	19
20	Administrator	2,080	2,080	64,692	31.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,776	2,102	26,327	12.52	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	3,524	3,524	89,612	25.43	33
34	TOTAL (lines 1 - 33)	90,126	93,831	\$ 1,375,195 *	\$ 14.66	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	20,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,949	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)		\$ 24,349		49

C. CONTRACT NURSES

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

Polo Rehabilitation & HCC
0052647

Period Beginning 1/1/2014

Period End 12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	66,566	32.00
Transportation	152	152	2,392	15.74
Marketing	1,292	1,292	20,654	15.99
TOTAL	3,524	3,524	89,612	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Biller	Administrator	0	\$ 64,692	Workers' Compensation Insurance	\$ 56,940	IDPH License Fee	\$ 3,489	
				Unemployment Compensation Insurance	39,243	Advertising: Employee Recruitment	2,511	
				FICA Taxes	93,800	Health Care Worker Background Check		
				Employee Health Insurance	12,328	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	926	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	675	
				Employee Relations	9,659	Miscellaneous Dues & Subscriptions	449	
				Employee Retirement	292	Home Office Allocation	3,607	
				Home Office Allocation	16,279			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,692	TOTAL (agree to Schedule V, line 22, col.8)		\$ 11,378		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(279)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 227,600				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 227,600				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 3,668				Out-of-State Travel	\$
Frontier	Computer Services		894					
Honkamp Kruger & Co.	Accounting Fees		684					
Odessian LLC	Data Services		75	N/A			In-State Travel	
Illinois Sec of State	Filing Fees		130					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 5,451	TOTAL		\$	Seminar Expense	
							Home Office Allocation	
							25	
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 25	

* Attach copy of IMRF notifications

**See instructions.

Polo Rehabilitation & HCC**0052647****Period Beginning****1/1/2014****Period End****12/31/2014****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,451
Home Office Allocation		
Lexis Nexis	Legal	7
GoffWilson	Legal	442
Illinois Secretary of State	Legal	40
Bank of America	Legal	134
Healthcare Resources International	Legal	80
Miscellaneous	Legal	17
Addy, Bush	Legal	11
Hall, Rustom, and Fritz	Legal	13
Black, Hedin, Ballard	Legal	23
SmithAmundsen	Legal	24
Applegate and Thorne	Legal	1,259
Healthcare Resources	Legal	761
ETS Environmental	Legal	69
IL Secretary of State	Legal	14
CliftonLarson Allen	Accountants	942
Ginoli & Co.	Accountants	3,356
Wells Fargo	Accountants	1,052
Miscellaneous	Computer Services	17
Odessian LLC	Computer Services	6
Optimizer	Computer Services	37
Allpayer Exchange	Computer Services	12
CCH	Computer Services	20
Prism Software	Computer Services	60
Macquarie Technology Services	Computer Services	52
Advanced Answers on Demand	Computer Services	2,791
Stratus Networks	Computer Services	368
Kemper Technology	Computer Services	1,088
AT&T	Computer Services	5
Ability Network	Computer Services	422
Barracuda	Computer Services	96
CIAN	Computer Services	115
Comcast	Computer Services	29
Emdeon	Computer Services	75
Charter Communications	Computer Services	5
E-Health Data Solutions	Computer Services	214
Crawford County Title Co.	Other Prof Fees	5
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	33
All Scripts	Other Prof Fees	22
Miscellaneous	Other Prof Fees	3
Marotta Gund Budd Derza	Other Prof Fees	6,173
Polsinelli	Other Prof Fees	231
Total (agree to Schedule V, line 19, column 8)		<u>25,577</u>

Facility Name & ID Number Polo Rehabilitation & HCC# 0052647

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. \$ 13,136 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. \$ 159,919
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,924
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,047
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adquate 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 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