		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: 0046425

Facility Name: Sullivan Rehab & HCC

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

County: Moultrie

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

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 # ( )

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,010	3,637	3,930	22,577	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,010	3,637	3,930	22,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.29%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/3/03

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 3,250

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,347	13,089		175,436		175,436	7,631	183,067			1
2	Food Purchase		147,995		147,995		147,995	(3,558)	144,437			2
3	Housekeeping	139,948	24,285		164,233		164,233	47	164,280			3
4	Laundry		15,906		15,906		15,906		15,906			4
5	Heat and Other Utilities			185,734	185,734		185,734	286	186,020			5
6	Maintenance	62,199	18,239	16,947	97,385		97,385	2,868	100,253			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	364,494	219,514	202,681	786,689		786,689	7,274	793,963			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	27	12,027			9
10	Nursing and Medical Records	1,117,352	148,756	78,941	1,345,049		1,345,049	(18)	1,345,031			10
10a	Therapy	30,022	496	343,279	373,797		373,797		373,797			10a
11	Activities	26,143	561	24,241	50,945		50,945	(274)	50,671			11
12	Social Services	37,257			37,257		37,257		37,257			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	1,210,774	149,813	458,461	1,819,048		1,819,048	(265)	1,818,783			16
	C. General Administration											
17	Administrative			268,600	268,600		268,600	(203,814)	64,786			17
18	Directors Fees											18
19	Professional Services			8,644	8,644		8,644	27,126	35,770			19
20	Dues, Fees, Subscriptions & Promotions			9,100	9,100		9,100	(420)	8,680			20
21	Clerical & General Office Expenses	32,448	5,400	34,759	72,607		72,607	84,783	157,390			21
22	Employee Benefits & Payroll Taxes			231,133	231,133		231,133	18,049	249,182			22
23	Inservice Training & Education							34	34			23
24	Travel and Seminar							30	30			24
25	Other Admin. Staff Transportation			2,074	2,074		2,074	4,633	6,707			25
26	Insurance-Prop.Liab.Malpractice			41,055	41,055		41,055	668	41,723			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	32,448	5,400	595,365	633,213		633,213	(68,911)	564,302			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,607,716	374,727	1,256,507	3,238,950		3,238,950	(61,902)	3,177,048			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sullivan Rehab & HCC #0046425 **Report Period Beginning:** 1/1/14 **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			57,115	57,115		57,115	11,915	69,030			30
31	Amortization of Pre-Op. & Org.							20,903	20,903			31
32	Interest			68,526	68,526		68,526	2,193	70,719			32
33	Real Estate Taxes			48,928	48,928		48,928	266	49,194			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,605	30,605		30,605	1,129	31,734			35
36	Other (specify):*											36
37	**TOTAL Ownership**			205,174	205,174		205,174	36,406	241,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,800		102,800		102,800		102,800			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,484	191,484		191,484		191,484			42
43	Other (specify):*		375	66,615	66,990		66,990	(66,990)				43
44	**TOTAL Special Cost Centers**		103,175	258,099	361,274		361,274	(66,990)	294,284			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,607,716	477,902	1,719,780	3,805,398		3,805,398	(92,486)	3,712,912			45

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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	(3,648)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,694)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,329)	30		9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	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	(34,237)	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				24
25	Fund Raising, Advertising and Promotional	(2,760)	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	(19,156)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,078)		$	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)	(17,408)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,408)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (92,486)		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

Sullivan Rehab & HCC

ID# 0046425

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (8,258)	43	1
2	X-Rays-Part A	(6,966)	43	2
3	Resident Flowers	(895)	43	3
4	Offset Miscellaneous Transportation Revenue	(274)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(31)	21	5
6	Pet Expense	(1,252)	43	6
7	Offset Chamber of Commerce Dues	(741)	20	7
8	Disallowed Marketing	(375)	43	8
9	Disallowed Special Event	(324)	43	9
10	Offset Miscellaenous Nursing Supply Revenue	(40)	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**	(19,156)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	3,324	0	0	4,307	0	0	0	0	0	0	7,631	1
2	Food Purchase	(3,648)	80	0	0	10	0	0	0	0	0	0	(3,558)	2
3	Housekeeping	0	17	0	0	30	0	0	0	0	0	0	47	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	224	0	0	62	0	0	0	0	0	0	286	5
6	Maintenance	0	1,261	0	0	1,607	0	0	0	0	0	0	2,868	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,648)	4,906	0	0	6,016	0	0	0	0	0	0	7,274	8
	B. Health Care and Programs													
9	Medical Director	0	27	0	0	0	0	0	0	0	0	0	27	9
10	Nursing and Medical Records	(40)	1	0	0	21	0	0	0	0	0	0	(18)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(274)	0	0	0	0	0	0	0	0	0	0	(274)	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**	(314)	28	0	0	21	0	0	0	0	0	0	(265)	16
	C. General Administration													
17	Administrative	0	0	0	0	(203,814)	0	0	0	0	0	0	(203,814)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,867	0	17,784	6,475	0	0	0	0	0	0	27,126	19
20	Fees, Subscriptions & Promotions	(741)	0	160	109	52	0	0	0	0	0	0	(420)	20
21	Clerical & General Office Expenses	(31)	0	37,415	129	47,270	0	0	0	0	0	0	84,783	21
22	Employee Benefits & Payroll Taxes	0	0	1,701	41	16,307	0	0	0	0	0	0	18,049	22
23	Inservice Training & Education	0	0	19	0	15	0	0	0	0	0	0	34	23
24	Travel and Seminar	0	0	12	0	18	0	0	0	0	0	0	30	24
25	Other Admin. Staff Transportation	0	0	3,026	0	1,607	0	0	0	0	0	0	4,633	25
26	Insurance-Prop.Liab.Malpractice	0	0	533	0	135	0	0	0	0	0	0	668	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(772)	2,867	42,866	18,063	(131,935)	0	0	0	0	0	0	(68,911)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,734)	7,801	42,866	18,063	(125,898)	0	0	0	0	0	0	(61,902)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	(3,329)	0	3,056	11,981	207	0	0	0	0	0	0	11,915	30
31	Amortization of Pre-Op. & Org.	0	0	0	20,903	0	0	0	0	0	0	0	20,903	31
32	Interest	(25)	0	1,943	0	275	0	0	0	0	0	0	2,193	32
33	Real Estate Taxes	0	0	150	0	116	0	0	0	0	0	0	266	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	769	0	360	0	0	0	0	0	0	1,129	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,354)	0	5,918	32,884	958	0	0	0	0	0	0	36,406	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):*	(66,990)	0	0	0	0	0	0	0	0	0	0	(66,990)	43
44	**TOTAL Special Cost Centers**	(66,990)	0	0	0	0	0	0	0	0	0	0	(66,990)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,078)	7,801	48,784	50,947	(124,940)	0	0	0	0	0	0	(92,486)	45

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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%	$ 3,324	$ 3,324	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	80	80	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	224	224	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,261	1,261	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%	27	27	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%	2,867	2,867	12
13	V								13
14	Total			$			$ 7,801	$ * 7,801	14

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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		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%	$ 160	$ 160	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	37,415	37,415	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,701	1,701	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	19	19	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	12	12	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,026	3,026	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	533	533	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%	3,056	3,056	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,943	1,943	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	150	150	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	769	769	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			$			$ 48,784	$ * 48,784	39

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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	Resident D	$	Petersen Health Care II, Inc.	100.00%	$ 0	$	15
16	V	2	Food	Resident Days		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping	Resident Days		Petersen Health Care II, Inc.	100.00%	0		17
18	V	5	Utilities	Resident Days		Petersen Health Care II, Inc.	100.00%	0		18
19	V	6	Maintenance	Resident Days		Petersen Health Care II, Inc.	100.00%	0		19
20	V	7	Mgmt. Allocation of Bene	Resident Days		Petersen Health Care II, Inc.	100.00%	0		20
21	V	9	Medical Director	Resident Days		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Rec	Resident Days		Petersen Health Care II, Inc.	100.00%	0		22
23	V	10A	Therapy	Resident Days		Petersen Health Care II, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Bene	Resident Days		Petersen Health Care II, Inc.	100.00%	0		24
25	V	17	Administrative	Resident Days		Petersen Health Care II, Inc.	100.00%	0		25
26	V	19	Professional Services	Resident Days		Petersen Health Care II, Inc.	100.00%	17,784	17,784	26
27	V	20	Dues, Fees, Subs & Prom	Resident Days		Petersen Health Care II, Inc.	100.00%	109	109	27
28	V	21	Clerical and General Offi	Resident Days		Petersen Health Care II, Inc.	100.00%	129	129	28
29	V	22	Employee Benefits and Pa	Resident Days		Petersen Health Care II, Inc.	100.00%	41	41	29
30	V	23	Inservice Training & Edu	Resident Days		Petersen Health Care II, Inc.	100.00%	0		30
31	V	24	Travel and Seminar	Resident Days		Petersen Health Care II, Inc.	100.00%	0		31
32	V	25	Other Admin. Staff Trans	Resident Days		Petersen Health Care II, Inc.	100.00%	0		32
33	V	26	Insurance-Prop./Liab./Ma	Resident Days		Petersen Health Care II, Inc.	100.00%	0		33
34	V	27	Mgmt. Allocation of Bene	Resident Days		Petersen Health Care II, Inc.	100.00%	0		34
35	V	30	Depreciation	Resident Days		Petersen Health Care II, Inc.	100.00%	11,981	11,981	35
36	V	31	Amortization	Resident Days		Petersen Health Care II, Inc.	100.00%	20,903	20,903	36
37	V	33	Real Estate Taxes	Resident Days		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehic	Resident Days		Petersen Health Care II, Inc.	100.00%	0		38
39	Total				$			$ 50,947	$ * 50,947	39

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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.		$ 4,307	$ 4,307	15
16	V	2	Food		Petersen Health Care Management, Inc.		10	10	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.		30	30	17
18	V	5	Utilities		Petersen Health Care Management, Inc.		62	62	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.		1,607	1,607	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.		21	21	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	268,600	Petersen Health Care Management, Inc.		64,786	(203,814)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.		6,475	6,475	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.		52	52	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.		47,270	47,270	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.		16,307	16,307	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.		15	15	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.		18	18	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.		1,607	1,607	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.		135	135	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.		0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.		207	207	35
36	V	32	Interest		Petersen Health Care Management, Inc.		275	275	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.		116	116	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.		360	360	38
39	Total			$ 268,600			$ 143,660	$ * (124,940)	39

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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 Systen	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 V	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care X	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 Sullivan Rehab & HCC # 0046425 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: Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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 Sullivan Rehab & HCC # 0046425 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Sullivan Rehab & HCC # 0046425 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	22,577	$ 3,324	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	22,577	80	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	22,577	17	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	22,577	224	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	22,577	1,261	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,577	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	22,577	27	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	22,577	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	22,577	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,577	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	22,577	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	22,577	2,867	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	22,577	160	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	22,577	37,415	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	22,577	1,701	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	22,577	19	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	22,577	12	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	22,577	3,026	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	22,577	533	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,577	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	22,577	3,056	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	22,577	1,943	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	22,577	150	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	22,577	769	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 56,585	25

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 [ ]

Name of Related Organization: Petersen Health Care II, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

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

	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	7	$	$	22,577	$	1
2	2	Food	Resident Days	1,572,338	7			22,577		2
3	3	Housekeeping	Resident Days	1,572,338	7			22,577		3
4	5	Utilities	Resident Days	1,572,338	7			22,577		4
5	6	Maintenance	Resident Days	1,572,338	7			22,577		5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	7			22,577		6
7	9	Medical Director	Resident Days	1,572,338	7			22,577		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	7			22,577		8
9	10A	Therapy	Resident Days	1,572,338	7			22,577		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	7			22,577		10
11	17	Administrative	Resident Days	1,572,338	7			22,577		11
12	19	Professional Services	Resident Days	1,572,338	7	132,319		22,577	17,784	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	7	810		22,577	109	13
14	21	Clerical and General Office	Resident Days	1,572,338	7	959		22,577	129	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	7	302		22,577	41	15
16	23	Inservice Training & Education	Resident Days	1,572,338	7			22,577		16
17	24	Travel and Seminar	Resident Days	1,572,338	7			22,577		17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	7			22,577		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	7			22,577		19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	7			22,577		20
21	30	Depreciation	Resident Days	1,572,338	7	89,145		22,577	11,981	21
22	31	Amortization	Resident Days	1,572,338	7	155,529		22,577	20,903	22
23	33	Real Estate Taxes	Resident Days	1,572,338	7			22,577		23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	7			22,577		24
25	TOTALS					$ 379,064	$		$ 50,947	25

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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 ☐

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

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

	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	22,577	$ 4,307	1
2	2	Food	Resident Days	1,572,338	77	675		22,577	10	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	22,577	30	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		22,577	62	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	22,577	1,607	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,577		6
7	9	Medical Director	Resident Days	1,572,338	77			22,577		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		22,577	21	8
9	10A	Therapy	Resident Days	1,572,338	77			22,577		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,577		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	22,577	64,786	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		22,577	6,475	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		22,577	52	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	22,577	47,270	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		22,577	16,307	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		22,577	15	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		22,577	18	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		22,577	1,607	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		22,577	135	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,577		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		22,577	207	21
22	32	Interest	Resident Days	1,572,338	77	19,133		22,577	275	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		22,577	116	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		22,577	360	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 143,660	25

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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**		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	First Merit		X	Mortgage	Varies	2/1/12	$ 1,743,600	$ 1,602,420	1/31/17	Varies	$ 68,526	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,743,600	$ 1,602,420			$ 68,526	9
	B. Non-Facility Related*											
10								Interest Income Offset			(25)	10
11								Home Office Allocation-PHC			1,943	11
12								Home Office Allocation-PHCM			275	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,193	14
15	TOTALS (line 9+line14)						$ 1,743,600	$ 1,602,420			$ 70,719	15

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

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

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2013 report.		$ 46,692	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 47,104	2
3. Under or (over) accrual (line 2 minus line 1).		$ 412	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,516	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.)**	Home Office Allocation	266 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,194	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2009	42,056	8
2010	42,469	9
2011	44,333	10
2012	45,332	11
2013	47,104	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 Sullivan Rehab & HCC COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 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)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	08-08-11-400-004	Long-Term Care Facility	$ 46,730.46	$ 46,730.46
2.	08-08-12-300-073	Long-Term Care Facility	$ 373.94	$ 373.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,104.40	$ 47,104.40

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 Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 777,645 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 20,903 4. Dates Incurred: 2010-2012 Refinancing

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	339,095	2003	$ 100,001	1
2					2
3	TOTALS	339,095		$ 100,001	3

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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		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	123		2003	1975	$ 1,560,545	$	39	$ 40,014	$ 40,014	$ 453,492	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2004	4,808		25	192	192	1,968	9
10	Fire Alarms			2004	1,524		25	61	61	600	10
11	Doors			2004	3,067		5			3,067	11
12	Smoke Alarms			2004	1,227		7			1,227	12
13	Land Improvements			2006	7,262		15	484	484	4,114	13
14	New Roof			2006	28,308		25	1,132	1,132	9,622	14
15	Kitchen Remodel			2006	22,241		25	890	890	7,565	15
16	Landscaping			2006	2,434		15	162	162	1,377	16
17	Sidewalks			2007	1,785		15	120	120	900	17
18	Sprinkler System			2008	14,839		25	594	594	3,861	18
19	Back Flow			2009	5,470		7	782	782	4,301	19
20	Water Heater			2009	2,983		5	301	301	2,983	20
21	Roof Repairs			2011	2,536		7	362	362	1,267	21
22	Nurses Station			2013	17,449		15	1,164	1,164	1,746	22
23	Tiling of Shower			2014	8,225		15	457	457	457	23
24	Water Heater-LA			2014	3,493		7	374	374	374	24
25	Roof Repairs			2014	2,800		7	267	267	267	25
26	Roof Replacement			2014	6,764		25	158	158	158	26
27	Roof Replacement			2014	12,600		25	294	294	294	27
28	Fencing			2014	3,395		15	132	132	132	28
29	Grease Trap Repair			2014	5,222		7	373	373	373	29
30	Water Heater			2014	3,375		7	201	201	201	30
31	A/C Unit - Roof Top			2014	8,384		15	186	186	186	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 Sullivan Rehab & HCC # 0046425 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			765			(765)		63
64	Building Booked			40,014			(40,014)		64
65	Building Improvement Booked			7,580			(7,580)		65
66									66
67	2014-Home Office Allocation-Building Improvements		10,539			253	253		67
68	2014-Home Office Allocation-Land Improvements		984			54	54		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,742,259	$ 48,359		$ 49,007	$ 648	$ 500,532	70

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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	$ 50,275	$ 8,697	$ 5,027	$ (3,670)	5-10 yrs.	$ 27,271	71
72	Current Year Purchases	2,459	59	59		10 yrs.	59	72
73	Fully Depreciated Assets	615,105					615,105	73
74	Home Office Allocation			14,937	14,937			74
75	TOTALS	$ 667,839	$ 8,756	$ 20,023	$ 11,267		$ 642,435	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2003 Ford	2003	$ 31,116	$		$		$ 31,116	76
77										77
78										78
79										79
80	TOTALS			$ 31,116	$	$	$		$ 31,116	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,541,215	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,030	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,915	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,174,083	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 Sullivan Rehab & HCC # 0046425 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: $ 21,592 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250 Van	$ 845.17	$ 10,142	17
18					18
19					19
20					20
21	TOTAL		$ 845.17	$ 10,142	21

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

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

Sullivan Rehab & HCC
0046425
Period Beginning 1/1/2014
Period End 12/31/2014

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$ 15,622
Dishwasher	117
Laundry Equipment	
Copier	4,724
Home Office Allocation	1,129
	21,592

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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.

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)		hrs	$	5,126	$ 76,883	$	5,126	$ 76,883	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		4,882	73,236		4,882	73,236	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2) & 10A(3)		hrs		12,848	192,724	496	12,848	193,220	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				102,800		102,800	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): PT Aides	10A(1)	2091	hrs	30,022				2,091	30,022	12
13	Other (specify): Respiratory Therapy	10A(3)				29	436		29	436	13
14	TOTAL				$ 30,022	22,885	$ 343,279	$ 103,296	24,976	$ 476,597	14

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 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	$ 1,517,331	$ 1,517,331	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,073)	1,228,943	1,228,943	3
4	Supply Inventory (priced at)	13,122	13,122	4
5	Short-Term Investments			5
6	Prepaid Insurance	43,844	43,844	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(34,406)	(34,406)	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,768,834	$ 2,768,834	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,571,084	14
15	Leasehold Improvements, at Historical Cost	154,414	171,175	15
16	Equipment, at Historical Cost	703,260	698,955	16
17	Accumulated Depreciation (book methods)	(1,183,544)	(1,174,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): PPD Lease/Mgmt/Other	2,496	2,496	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,348,652	$ 1,369,628	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,117,486	$ 4,138,462	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 993,398	$ 993,398	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,459	98,459	30
31	Accrued Taxes Payable (excluding real estate taxes)	144,495	144,495	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,516	48,516	32
33	Accrued Interest Payable	5,919	5,919	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	3,202	3,202	36
37	Accrued Management Fees			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,293,989	$ 1,293,989	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,602,420	1,602,420	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other & IL State Police	12,286	12,286	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,614,706	$ 1,614,706	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,908,695	$ 2,908,695	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,208,791	$ 1,229,767	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,117,486	$ 4,138,462	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,144,363	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,144,363	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,428	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)**	$ 64,428	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)**	$ 1,208,791	24 *

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

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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	$ 3,601,008	1
2	Discounts and Allowances for all Levels	(668,615)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,932,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	706,739	6
7	Oxygen	341	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 707,080	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	3,648	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	196,756	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,489	20
21	Other Medical Services	15,090	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Revenue	71	28
28a	Transportation Revenue	274	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 345	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,869,826	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	786,689	31
32	Health Care	1,819,048	32
33	General Administration	633,213	33
	B. Capital Expense		
34	Ownership	205,174	34
	C. Ancillary Expense		
35	Special Cost Centers	169,790	35
36	Provider Participation Fee	191,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,805,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	64,428	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 64,428	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,766,533	44
45	Private Pay - Net Inpatient Revenue	524,275	45
46	Medicare - Net Inpatient Revenue	675,035	46
47	Other-(specify) Veterans -Net Patient Revenue		47
48	Other-(specify) Charity and Insurance Contractual Allowance	(33,450)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,932,393	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 Sullivan Rehab & HCC # 0046425 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	$ 70,268	$ 33.78	1
2	Assistant Director of Nursing	612	700	16,494	23.56	2
3	Registered Nurses	2,694	2,723	67,475	24.78	3
4	Licensed Practical Nurses	16,929	17,783	356,756	20.06	4
5	CNAs & Orderlies	47,871	49,402	556,470	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,925	2,091	30,022	14.36	8
9	Activity Director	1,945	2,097	26,143	12.47	9
10	Activity Assistants					10
11	Social Service Workers	1,904	2,132	37,257	17.48	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,291	18.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,005	13,836	123,056	8.89	15
16	Dishwashers					16
17	Maintenance Workers	3,525	3,597	62,199	17.29	17
18	Housekeepers	14,573	14,968	139,948	9.35	18
19	Laundry					19
20	Administrator	2,080	2,080	64,786	31.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,060	2,157	32,448	15.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CPC	2,000	2,099	49,889	23.77	33
34	TOTAL (lines 1 - 33)	115,283	119,825	$ 1,672,502 *	$ 13.96	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	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,826	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	209	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)	4	$ 17,035		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,994	$ 59,080	L10, C3	50
51	Licensed Practical Nurses	59	1,901	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,053	$ 60,981		53

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chuck Pullen	Administrator	0	$ 64,786
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,786

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 268,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 268,600

C. Professional Services

Vendor/Payee	Type	Amount
Allscripts	Data Services	$ 1,948
Mediacom	Computer Services	1,681
Honkamp, Krueger and Co.	Accounting Services	786
Moultrie Co. Circuit Clerk	Filing Fees	35
E-Health Data Services	Computer Services	4,194
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 8,644

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,831
Unemployment Compensation Insurance	36,991
FICA Taxes	115,361
Employee Health Insurance	(11,599)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	16,092
Employee Retirement	1,457
Home Office Allocation	18,049
TOTAL (agree to Schedule V, line 22, col.8)	$ 249,182

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	46
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 100	1,008
Miscellaneous Licenses & Permits	4,105
Miscellaneous Dues & Subscriptions	3,941
Home Office Allocation	321
Less: Public Relations Expense	(741)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,680

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	30
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30

* Attach copy of IMRF notifications

**See instructions.

Sullivan Rehab & HCC
0046425

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)		8,644
Home Office Allocation-PHC, PHCM, & PHC II		
Lexis Nexis	Legal	7
GoffWilson	Legal	526
Illinois Secretary of State	Legal	47
Bank of America	Legal	159
Healthcare Resources International	Legal	95
Miscellaneous	Legal	20
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	16
Black, Hedin, Ballard	Legal	28
SmithAmundsen	Legal	28
Touhy, Touhy, Buehler	Legal	1,579
CliftonLarson Allen	Accountants	1,697
Ginoli & Co.	Accountants	3,347
Miscellaneous	Computer Services	20
Odessian LLC	Computer Services	7
Optimizer	Computer Services	45
Allpayer Exchange	Computer Services	14
CCH	Computer Services	23
Prism Software	Computer Services	72
Macquarie Technology Services	Computer Services	62
Advanced Answers on Demand	Computer Services	3,316
Stratus Networks	Computer Services	437
Kemper Technology	Computer Services	1,294
AT&T	Computer Services	5
Ability Network	Computer Services	501

Barracuda	Computer Services	114
CIAN	Computer Services	136
Comcast	Computer Services	34
Emdeon	Computer Services	88
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	4
David Budde	Other Prof Fees	39
All Scripts	Other Prof Fees	27
Miscellaneous	Other Prof Fees	4
Marotta Gund Bund Derza	Other Prof Fees	13,306
Total (agree to Schedule V, line 19, column 8)		35,765

Facility Name & ID Number Sullivan Rehab & HCC # 0046425 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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Sullivan Rehab & HCC** **#** **0046425** **Report Period Beginning:** **1/1/14** **Ending:** **12/31/14**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$3,200**

(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. $ **22,670** 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. $ **191,484**
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. $ **3,648**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.