FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047415

Facility Name: Bloomington Rehab & HCC

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

County: McLean

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 673-3009
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 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		2,051	1,324	3,375	8
9	SNF/PED					9
10	ICF	15,473			15,473	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,473	2,051	1,324	18,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.20%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,186

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	103,795	16,004		119,799		119,799	3,872	123,671			1
2	Food Purchase		132,464		132,464		132,464	(1,577)	130,887			2
3	Housekeeping	78,470	18,659		97,129		97,129	68	97,197			3
4	Laundry	38,719	10,197		48,916		48,916		48,916			4
5	Heat and Other Utilities			43,039	43,039		43,039	226	43,265			5
6	Maintenance	44,541	10,293	13,595	68,429		68,429	2,586	71,015			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	265,525	187,617	56,634	509,776		509,776	5,175	514,951			8
	B. Health Care and Programs											
9	Medical Director			23,200	23,200		23,200		23,200			9
10	Nursing and Medical Records	790,136	75,865	17,997	883,998		883,998	(11,258)	872,740			10
10a	Therapy		713	193,304	194,017		194,017		194,017			10a
11	Activities	40,375	351	8	40,734		40,734	(4,358)	36,376			11
12	Social Services	17,863			17,863		17,863		17,863			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	848,374	76,929	234,509	1,159,812		1,159,812	(15,616)	1,144,196			16
	C. General Administration											
17	Administrative			249,100	249,100		249,100	(174,166)	74,934			17
18	Directors Fees											18
19	Professional Services			7,365	7,365		7,365	22,610	29,975			19
20	Dues, Fees, Subscriptions & Promotions			6,299	6,299		6,299	412	6,711			20
21	Clerical & General Office Expenses	41,426	2,650	13,159	57,235		57,235	46,970	104,205			21
22	Employee Benefits & Payroll Taxes			146,882	146,882		146,882	25,237	172,119			22
23	Inservice Training & Education							87	87			23
24	Travel and Seminar							42	42			24
25	Other Admin. Staff Transportation			7,089	7,089		7,089	3,551	10,640			25
26	Insurance-Prop.Liab.Malpractice			19,510	19,510		19,510	16,306	35,816			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	41,426	2,650	449,404	493,480		493,480	(58,951)	434,529			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,155,325	267,196	740,547	2,163,068		2,163,068	(69,392)	2,093,676			29

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

Facility Name & ID Number Bloomington Rehab & HCC #0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,122	1,122		1,122	50,498	51,620			30
31	Amortization of Pre-Op. & Org.							9,450	9,450			31
32	Interest							88,425	88,425			32
33	Real Estate Taxes							23,180	23,180			33
34	Rent-Facility & Grounds			222,171	222,171		222,171	(222,171)				34
35	Rent-Equipment & Vehicles			34,793	34,793		34,793	812	35,605			35
36	Other (specify):*											36
37	**TOTAL Ownership**			258,086	258,086		258,086	(49,806)	208,280			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,538		35,538		35,538		35,538			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,450	150,450		150,450		150,450			42
43	Other (specify):*	32,461	148	23,867	56,476		56,476	(56,476)				43
44	**TOTAL Special Cost Centers**	32,461	35,686	174,317	242,464		242,464	(56,476)	185,988			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,187,786	302,882	1,172,950	2,663,618		2,663,618	(175,674)	2,487,944			45

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,647)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,978)	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	(1,609)	30		9
10	Interest and Other Investment Income	63	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	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	(7,620)	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	(33,770)	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	(23,831)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,470)		$	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)	(100,204)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (100,204)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (175,674)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Bloomington Rehab & HCC

ID# 0047415

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (4,494)	43	1
2	X-Rays-Part A	(3,328)	43	2
3	Special Events	(148)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(70)	21	4
5	Offset Transportation Trans. Revenue	(4,358)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(11,373)	10	6
7	Resident Flowers	(60)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	3,872	0	0	0	0	0	0	0	0	0	3,872	1
2	Food Purchase	(1,647)	70	0	0	0	0	0	0	0	0	0	(1,577)	2
3	Housekeeping	0	68	0	0	0	0	0	0	0	0	0	68	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	226	0	0	0	0	0	0	0	0	0	226	5
6	Maintenance	0	2,114	0	0	472	0	0	0	0	0	0	2,586	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,647)	6,350	0	0	472	0	0	0	0	0	0	5,175	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11,373)	115	0	0	0	0	0	0	0	0	0	(11,258)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,358)	0	0	0	0	0	0	0	0	0	0	(4,358)	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**	(15,731)	115	0	0	0	0	0	0	0	0	0	(15,616)	16
	C. General Administration													
17	Administrative	0	(174,166)	0	0	0	0	0	0	0	0	0	(174,166)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,859	0	10,431	2,320	0	0	0	0	0	0	22,610	19
20	Fees, Subscriptions & Promotions	0	0	412	0	0	0	0	0	0	0	0	412	20
21	Clerical & General Office Expenses	(70)	0	45,134	0	1,906	0	0	0	0	0	0	46,970	21
22	Employee Benefits & Payroll Taxes	0	0	25,237	0	0	0	0	0	0	0	0	25,237	22
23	Inservice Training & Education	0	0	87	0	0	0	0	0	0	0	0	87	23
24	Travel and Seminar	0	0	42	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	0	0	3,551	0	0	0	0	0	0	0	0	3,551	25
26	Insurance-Prop.Liab.Malpractice	0	0	500	0	15,806	0	0	0	0	0	0	16,306	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(70)	(164,307)	74,963	10,431	20,032	0	0	0	0	0	0	(58,951)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,448)	(157,842)	74,963	10,431	20,504	0	0	0	0	0	0	(69,392)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,609)	0	9,988	1,259	40,860	0	0	0	0	0	0	50,498	30
31	Amortization of Pre-Op. & Org.	0	0	0	2,308	7,142	0	0	0	0	0	0	9,450	31
32	Interest	63	0	293	15,718	72,351	0	0	0	0	0	0	88,425	32
33	Real Estate Taxes	0	0	230	0	22,950	0	0	0	0	0	0	23,180	33
34	Rent-Facility & Grounds	0	0	0	0	(222,171)	0	0	0	0	0	0	(222,171)	34
35	Rent-Equipment & Vehicles	0	0	812	0	0	0	0	0	0	0	0	812	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,546)	0	11,323	19,285	(78,868)	0	0	0	0	0	0	(49,806)	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):*	(56,476)	0	0	0	0	0	0	0	0	0	0	(56,476)	43
44	**TOTAL Special Cost Centers**	(56,476)	0	0	0	0	0	0	0	0	0	0	(56,476)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,470)	(157,842)	86,286	29,716	(58,364)	0	0	0	0	0	0	(175,674)	45

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. [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)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 3,872	$ 3,872	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	70	70	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	68	68	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	226	226	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,114	2,114	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	115	115	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	249,100	Petersen Health Care Management, Inc.	100.00%	74,934	(174,166)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	9,859	9,859	12
13	V								13
14	Total			$ 249,100			$ 91,258	$ * (157,842)	14

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 412	$ 412	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	45,134	45,134	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,237	25,237	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	87	87	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	42	42	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,551	3,551	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	500	500	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,988	9,988	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	293	293	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	230	230	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	812	812	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			$			$ 86,286	$ * 86,286	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	10,431	10,431	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	1,259	1,259	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	2,308	2,308	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	15,718	15,718	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			$			$ 29,716	$ * 29,716	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	6	Maintenance	$	Bloomington Land, LLC	100.00%	$ 472	$ 472	15
16	V	19	Professional Services	$	Bloomington Land, LLC	100.00%	$ 2,320	2,320	16
17	V	21	Equipment		Bloomington Land, LLC	100.00%	1,906	1,906	17
18	V	26	Insurance-Property		Bloomington Land, LLC	100.00%	3,352	3,352	18
19	V	26	Insurance-Mortgage Insurance		Bloomington Land, LLC	100.00%	12,454	12,454	19
20	V	30	Depreciation		Bloomington Land, LLC	100.00%	40,860	40,860	20
21	V	31	Amortization		Bloomington Land, LLC	100.00%	7,142	7,142	21
22	V	32	Interest	1,423	Bloomington Land, LLC	100.00%	73,774	72,351	22
23	V	33	Real Estate Taxes		Bloomington Land, LLC	100.00%	22,950	22,950	23
24	V	34	Rent-Income and Grounds	222,171	Bloomington Land, LLC	100.00%		(222,171)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 223,594			$ 165,230	$ * (58,364)	39

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	1,521,544	75	$ 312,540	$ 357,910	18,848	$ 3,872	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	18,848	70	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	18,848	68	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	18,848	226	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	18,848	2,114	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,848	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	18,848	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	18,848	115	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	18,848	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,848	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	18,848	74,934	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	18,848	9,859	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	18,848	412	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	18,848	45,134	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	18,848	25,237	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	18,848	87	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	18,848	42	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	18,848	3,551	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	18,848	500	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,848	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	18,848	9,988	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	18,848	293	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	18,848	230	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	18,848	812	24
25	TOTALS					$ 13,089,501	$ 11,510,481		$ 177,544	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	197,666	9	$	$	18,848	$	1
2	2	Food	Resident Days	197,666	9			18,848		2
3	3	Housekeeping	Resident Days	197,666	9			18,848		3
4	4	Laundry	Resident Days	197,666	9			18,848		4
5	5	Utilities	Resident Days	197,666	9			18,848		5
6	6	Maintenance	Resident Days	197,666	9			18,848		6
7	7	Mgmt. Allocation of Benefits	Resident Days	197,666	9			18,848		7
8	10	Nursing and Medical Records	Resident Days	197,666	9			18,848		8
9	15	Mgmt. Allocation of Benefits	Resident Days	197,666	9			18,848		9
10	17	Administrative	Resident Days	197,666	9			18,848		10
11	19	Professional Services	Resident Days	197,666	9	109,392		18,848	10,431	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	197,666	9			18,848		12
13	21	Clerical and General Office	Resident Days	197,666	9			18,848		13
14	22	Employee Benefits & Payroll	Resident Days	197,666	9			18,848		14
15	23	Inservice Training & Education	Resident Days	197,666	9			18,848		15
16	24	Travel and Seminar	Resident Days	197,666	9			18,848		16
17	25	Other Admin. Staff Transport.	Resident Days	197,666	9			18,848		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	197,666	9			18,848		18
19	30	Depreciation	Resident Days	197,666	9	13,207		18,848	1,259	19
20	31	Amortization	Resident Days	197,666	9	24,205		18,848	2,308	20
21	32	Interest	Resident Days	197,666	9	164,836		18,848	15,718	21
22	33	Real Estate Taxes	Resident Days	197,666	9			18,848		22
23	34	Rent-Facility and Grounds	Resident Days	197,666	9			18,848		23
24	35	Rent-Equipment & Vehicles	Resident Days	197,666	9			18,848		24
25	TOTALS					$ 311,640	$		$ 29,716	25

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capital Finance Group		X	Mortgage	Varies	1/1/2015	$ 2,019,400	$ 1,887,481	12/31/2024	Varies	$ 73,774	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,019,400	$ 1,887,481			$ 73,774	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,360)	10
11								Home Office Allocation-PHO			15,718	11
12								Home Office Allocation-PHCM			293	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,651	14
15	TOTALS (line 9+line14)						$ 2,019,400	$ 1,887,481			$ 88,425	15

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

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	23,051	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.)	$	22,661	2
3. Under or (over) accrual (line 2 minus line 1).	$	(390)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	23,340	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 230			
TOTAL REFUND $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	23,180	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	22,458	8
	2012	22,224	9
	2013	22,342	10
	2014	22,404	11
	2015	22,661	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bloomington Rehab & HCC COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-16-128-012	Long-Term Care Facility	$ 22,661.42	$ 22,661.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,661.42	$ 22,661.42

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 9,450 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	66,211	2005	$ 87,500	1
2					2
3	TOTALS	66,211		$ 87,500	3

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		2005	1972	$ 528,930	$	30	$ 20,800	$ 20,800	$ 239,200	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvement			2005	13,000		15	867	867	9,970	9
10	Sign			2005	458		10			458	10
11	Sidewalks			2005	3,850		15	257	257	2,698	11
12	Roof			2007	9,076		20	454	454	4,540	12
13	Backflow			2008	9,779		25	392	392	3,332	13
14	Carpet			2008	6,911		7			6,911	14
15	Sprinkler Installation			2009	13,662		15	911	911	6,832	15
16	Water Service Line Repair			2009	5,990		7	426	426	5,990	16
17	Parking Lot Repair			2011	38,631		15	2,576	2,576	12,448	17
18	Sidewalk repair			2011	5,545		15	370	370	2,035	18
19	Sprinkler Work			2012	16,800		15	1,120	1,120	6,160	19
20	Water Leak Repair			2012	9,216		7	1,316	1,316	5,922	20
21	Roof Replacement			2013	60,115		25	2,405	2,405	8,417	21
22	Sprinkler Pipe Repair			2015	3,100		7	444	444	666	22
23	Attic Piping Repair			2015	6,044		7	864	864	1,296	23
24	Exterior Landscaping			2016	13,563		7	969	969	969	24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,236			(1,236)		30
31	Building Booked					20,827			(20,827)		31
32	Building Improvement Booked					12,751			(12,751)		32
33											33
34	2016-Home Office Allocation-Building Improvements				8,321			200	200		34
35	2016-Home Office Allocation-Land Improvements				766			50	50		35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 753,757	$ 34,814		$ 34,421	$ (393)	$ 317,844	70

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 54,115	$ 7,015	$ 5,283	$ (1,732)	5-10 yrs.	$ 22,546	71
72	Current Year Purchases	12,873	153	919	766	7 yrs.	919	72
73	Fully Depreciated Assets	116,111					116,111	73
74	Home Office Allocation			10,997	10,997			74
75	TOTALS	$ 183,099	$ 7,168	$ 17,199	$ 10,031		$ 139,576	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)	$ 1,024,356	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,982	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,620	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,638	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 457,420	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			93
94	N/A		94
95		$	95

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

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 29,584 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	$ 355	$ 6,021	17
18					18
19					19
20					20
21	TOTAL		$ 354.87	$ 6,021	21

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

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

Bloomington Rehab & HCC
0047415
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	23,554
Dishwasher		707
Generator		27
Copier		4,484
Home Office Allocation		812
		29,584

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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(2), 10A(3)	hrs	$	5,579	$ 83,692	$ 462	5,579	$ 84,154	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,307	19,606		1,307	19,606	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,000	90,006	251	6,000	90,257	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				35,538		35,538	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			$	12,886	$ 193,304	$ 36,251	12,886	$ 229,555	14

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

STATE OF ILLINOIS

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ (597,361)	$ (597,361)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,594)	1,202,590	1,202,590	3
4	Supply Inventory (priced at Cost)	8,321	8,321	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,180	32,583	6
7	Other Prepaid Expenses		18,410	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 635,730	$ 664,543	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		448,387	12
13	Land		87,500	13
14	Buildings, at Historical Cost		537,251	14
15	Leasehold Improvements, at Historical Cost	13,563	216,506	15
16	Equipment, at Historical Cost	12,873	183,099	16
17	Accumulated Depreciation (book methods)	(1,122)	(457,420)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		157,125	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(16,070)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,314	$ 1,156,378	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 661,044	$ 1,820,921	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 428,100	$ 428,100	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,514	61,514	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,325	26,325	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,340	32
33	Accrued Interest Payable		6,056	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	231,556	231,556	36
37	Accrued Management Fees	57,520	57,520	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 805,015	$ 834,411	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,887,481	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	831,071	(17,057)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 831,071	$ 1,870,424	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,636,086	$ 2,704,835	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (975,042)	$ (883,914)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 661,044	$ 1,820,921	48

***(See instructions.)**

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,550,530)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments Made After Cost Report Was Filed**	(1,479)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,552,009)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	513,283	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	63,684	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)**	$ 576,967	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)**	$ (975,042)	24 *

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

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,908,855	1
2	Discounts and Allowances for all Levels	(166,303)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,742,552	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	326,893	6
7	Oxygen	349	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 327,242	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,647	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	66,959	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,522	20
21	Other Medical Services	17,241	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 91,369	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(63)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (63)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	4,358	28
28a	Miscellaneous Revenue	11,443	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,801	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,176,901	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	509,776	31
32	Health Care	1,159,812	32
33	General Administration	493,480	33
	B. Capital Expense		
34	Ownership	258,086	34
	C. Ancillary Expense		
35	Special Cost Centers	92,014	35
36	Provider Participation Fee	150,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,663,618	40
41	**Income before Income Taxes (line 30 minus line 40)****	513,283	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 513,283	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,286,863	44
45	Private Pay - Net Inpatient Revenue	300,278	45
46	Medicare - Net Inpatient Revenue	128,909	46
47	Other-(specify) Insurance Net Inpatient Revenue	26,502	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,742,552	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 70,424	$ 33.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,281	6,364	176,975	27.81	3
4	Licensed Practical Nurses	8,532	8,722	166,898	19.14	4
5	CNAs & Orderlies	27,131	27,696	329,330	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	11	11	166	15.09	9
10	Activity Assistants	1,964	2,073	23,630	11.40	10
11	Social Service Workers	1,706	1,817	17,863	9.83	11
12	Dietician					12
13	Food Service Supervisor	1,979	1,979	25,246	12.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,853	7,946	78,549	9.89	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,118	44,541	21.03	17
18	Housekeepers	7,676	7,828	78,470	10.02	18
19	Laundry	3,365	3,600	38,719	10.76	19
20	Administrator	2,080	2,080	74,934	36.03	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	32,461	15.61	22
23	Office Manager	1,969	2,137	41,426	19.39	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	1,568	1,668	46,509	27.88	32
33	Other(specify) Transportation	1,550	1,635	16,579	10.14	33
34	TOTAL (lines 1 - 33)	79,764	81,834	$ 1,262,720 *	$ 15.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	23,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,706	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	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)	2	$ 27,022		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	332	$ 12,967	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	332	$ 12,967		53

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janice Kindred	Administrator	0	$ 74,934
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,934

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 249,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 249,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 2,941
Comcast	Computer Services	1,017
Allscripts	Data Services	961
Honkamp Kruger	Accounting Fees	2,959
Erickson, David, Murphy, Johnson	Legal Fees	1,665
Ability Network	Computer Services	102
DeWitt Co Circuit Clerk	Legal Fees	40
Capital Finance Group	Refund of Refinancing Fees	(2,320)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 7,365

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,812
Unemployment Compensation Insurance	29,160
FICA Taxes	87,653
Employee Health Insurance	2,271
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	856
Employee Retirement	130
Home Office Allocation	25,237
TOTAL (agree to Schedule V, line 22, col.8)	$ 172,119

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	875
Health Care Worker Background Check	
(Indicate # of checks performed 18)	353
Patient Background Checks 50	1,005
Miscellaneous Licenses & Permits	1,042
Miscellaneous Dues & Subscriptions	3,024
Home Office Allocation	412
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,711

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	42
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 42

* Attach copy of IMRF notifications

**See instructions.

Bloomington Rehab & HCC
0047415
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,365
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	44
Miscellaneous	Legal	15
Miller Hall and Triggs	Legal	76
Healthcare Resources International	Legal	380
Hunziker Law	Legal	91
Lexis Nexis	Legal	8
Illinois Secretary of State	Legal	26
Lane and Waterman	Legal	155
Quinn and Johnston	Legal	689
Peoria County Recorder	Legal	19
Capital Finance Group	Legal	
CliftonLarson Allen	Accountants	395
Ginoli & Co.	Accountants	5494
Capital Finance Group	Accountants	1,237
Miscellaneous	Computer Services	50
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3471
Stratus Networks	Computer Services	353
Kemper Technology	Computer Services	233
AT&T	Computer Services	5
Ability Network	Computer Services	1480
CIAN	Computer Services	176
Comcast	Computer Services	29
CCH	Computer Services	12
Charter Communications	Computer Services	34
Allscripts	Computer Services	516
ATS	Computer Services	233
Allpayer Exchange	Computer Services	12
Optimizer	Other Prof Fees	36
Ankura	Other Prof Fees	269
David Budde	Other Prof Fees	31
Bruner, Cooper, Zuck	Other Prof Fees	78
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4585
Professional Software and Services	Other Prof Fees	19
Hughes Valuation Services	Other Prof Fees	24
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		27,653

Facility Name & ID Number Bloomington Rehab & HCC # 0047415 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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-$1,000**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,201** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **150,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,647**

(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. $ **4,358**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate 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? **Yes**
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. $ **N/A**

(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. **No**
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT **Bloomington Rehab & H** **09:24 AM** **7/7/2017**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-175,674	equal to	-175,674	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	88,425	equal to	88,425	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	23,180	equal to	23,180	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	9,450	equal to	9,450	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	51,620	equal to	51,620	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	35,605	equal to	35,605	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	194,017	equal to	194,017	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	36,251	equal to	36,251	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	509,776	equal to	509,776	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,159,812	equal to	1,159,812	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	493,480	equal to	493,480	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	258,086	equal to	258,086	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	92,014	equal to	92,014	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	150,450	equal to	150,450	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	790,136	equal to	790,136	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	40,375	equal to	40,375	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,863	equal to	17,863	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	103,795	equal to	103,795	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	44,541	equal to	44,541	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	78,470	equal to	78,470	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	38,719	equal to	38,719	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	74,934	equal to	74,934	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	41,426	equal to	41,426	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,262,720	equal to	1,187,786	74,934	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	23,200	< or = to	23,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	16,788	< or = to	17,997	-1,209	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	8	-8	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	74,934	equal to	74,934	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	249,100	equal to	249,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	7,365	equal to	7,365	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	172,119	equal to	172,119	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,711	equal to	6,711	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	42	equal to	42	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	150,450	equal to	150,450	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,186	equal to	1,324	-138	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-100,204	equal to	-100,204	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,887,481	equal to	1,887,481	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	23,340	equal to	23,340	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	87,500	equal to	87,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	753,757	equal to	753,757	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	183,099	equal to	183,099	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	457,420	equal to	457,420	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-975,042	equal to	-975,042	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	513,283	equal to	513,283	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	661,044	equal to	661,044	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 7/7/2017 09:24:55 AM

HSA Number: 4 Name: **Bloomington Rehab & HCC**

Cost report peri From: 1/1/2016 To: 12/31/2016 Base Number: 492
If this is an ICF/DD 16 facility, e N
Licensed bed d 28,470 Occupancy: 18,848 Pct. of occupan 66.20%

ıblic Aid Support Rate: $

Genl Services S	265,525	Col 1, Line 8 ---Audit Adj:	
Genl Admin Sal	41,426	Col 1, Line 28 ---Audit Adj:	
Total Salary Wa	1,187,786	Col 1, Line 44 ---Audit Adj:	
Employee Bene	172,119	Col 8, Line 22 ---Audit Adj:	
Total General S	514,951	Col 8, Line 8 ---Audit Adj:	
Total General A	434,529	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$265,525
Divided by Total Wages (Column 1, Line 44)	$1,187,786
General service wages as percent of total wages	22.3546%
Employee Benefits (Column 10, Line 22)	$172,119
Allocation of Employee Benefits to General Services Costs	$38,477
Plus Total General Services (Column 10, Line 8)	$514,951
New Total General Services Cost	$553,428

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$41,426
Divided by Total Wages (Column 1, Line 45)	$1,187,786
General administration wages as a percent of total wages	3.4877%
Employee Benefits (Column 10, Line 22)	$172,119
Allocation of Emplayee Benefits to General Admin. Costs	$6,003
Plus Total General Administration (Column 10, Line 28)	$434,529
Minus Total Fringe (Column 10, Line 22)	$172,119
New Total General Administration Cost	$268,413

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	232	multiplied by 6 =	1392
Sum of the three lines			1399.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			492

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:	1
General Administration Multiplier:	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)	$553,428	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$553,428

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$268,413	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$268,413
3 Total Updated Support Costs (1 + 2)		$821,841

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $38.42

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$821,841
Total Patient Days (Cost Report)	18,848
Support Costs per Diem	$43.60

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	28,470
Multiplied by	0.93
	26,477
Minus total Patient Days	18,848
	7,629
One-third of difference	2,543
Plus Total Patient Days	18,848
Adjusted Occupancy	21,391
Total Support Costs (Step II, C, 3, above)	$821,841
Divided by Adjusted Occupany	21391
Support Costs Per Diem	$38.42

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$38.42
Difference	$9.02
Multiply the Difference by	0.5
One-Half of the Difference	$4.51
Plus Support Costs Per Diem	$38.42
Support Rate if costs are between 35th and 75th percentile	42.93

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$38.42
Difference	$9.02
Multiply the Difference by	0.5
One-Half of the Difference	$4.51
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$3.795
Plus Support Costs Per Diem	$38.42
Support Rate if support costs less than 35th percentile	$42.22

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$42.22**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	103,795	16,004	0	119,799	0	119,799	3,872	123,671
2. Food Purchase	0	132,464	0	132,464	0	132,464	-1,577	130,887
3. Housekeeping	78,470	18,659	0	97,129	0	97,129	68	97,197
4. Laundry	38,719	10,197	0	48,916	0	48,916	0	48,916
5. Heat and Other Utilities	0	0	43,039	43,039	0	43,039	226	43,265
6. Maintenance	44,541	10,293	13,595	68,429	0	68,429	2,586	71,015
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	265,525	187,617	56,634	509,776	0	509,776	5,175	514,951
9. Medical Director	0	0	23,200	23,200	0	23,200	0	23,200
10. Nursing & Medical Records	790,136	75,865	17,997	883,998	0	883,998	-11,258	872,740
10a. Therapy	0	713	193,304	194,017	0	194,017	0	194,017
11. Activities	40,375	351	8	40,734	0	40,734	-4,358	36,376
12. Social Services	17,863	0	0	17,863	0	17,863	0	17,863
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	848,374	76,929	234,509	1,159,812	0	1,159,812	-15,616	#######
17. Administrative	0	0	249,100	249,100	0	249,100	-174,166	74,934
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,365	7,365	0	7,365	22,610	29,975
20. Fees, Subscriptions & Promotion	0	0	6,299	6,299	0	6,299	412	6,711
21. Clerical & General Office	41,426	2,650	13,159	57,235	0	57,235	46,970	104,205
22. Employee Benefits & Payroll	0	0	146,882	146,882	0	146,882	25,237	172,119
23. Inservice Training & Education	0	0	0	0	0	0	87	87
24. Travel and Seminar	0	0	0	0	0	0	42	42
25. Other Admin. Staff Trans	0	0	7,089	7,089	0	7,089	3,551	10,640
26. Insurance-Prop.Liab.Malpractice	0	0	19,510	19,510	0	19,510	16,306	35,816
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	41,426	2,650	449,404	493,480	0	493,480	-58,951	434,529
29. Total General Administrative	1,155,325	267,196	740,547	2,163,068	0	2,163,068	-69,392	#######
30. Depreciation	0	0	1,122	1,122	0	1,122	50,498	51,620
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	9,450	9,450
32. Interest	0	0	0	0	0	0	88,425	88,425
33. Real Estate	0	0	0	0	0	0	23,180	23,180
34. Rent - Facility & Grounds	0	0	222,171	222,171	0	222,171	-222,171	0
35. Rent - Equipment & Vehicles	0	0	34,793	34,793	0	34,793	812	35,605
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	258,086	258,086	0	258,086	-49,806	208,280
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	35,538	0	35,538	0	35,538	0	35,538
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	150,450	150,450	0	150,450	0	150,450
43. Other (specify):*	32,461	148	23,867	56,476	0	56,476	-56,476	0
44. Total Special Cost Ce	32,461	35,686	174,317	242,464	0	242,464	-56,476	185,988
45. Grand Total	1,187,786	302,882	1,172,950	2,663,618	0	2,663,618	-175,674	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-597,361	-597,361
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,202,590	1,202,590
4. Supply Inventory	8,321	8,321
5. Short-Term Investments	0	0
6. Prepaid Insurance	22,180	32,583
7. Other Prepaid Expenses	0	18,410
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	635,730	664,543
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	448,387
13. Land	0	87,500
14. Buildings, at Historical Cost	0	537,251
15. Leasehold Improvements, Historical Cost	13,563	216,506
16. Equipment, at Historical Cost	12,873	183,099
17. Accumulated Depreciation (book methods)	-1,122	-457,420
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	157,125
20. Accum Amort - Org/Pre-Op Costs	0	-16,070
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	25,314	1,156,378
25. Total Assets	661,044	1,820,921
CURRENT LIABILITIES		
26. Accounts Payable	428,100	428,100
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	61,514	61,514
31. Accrued Taxes Payable	26,325	26,325
32. Accrued Real Estate Taxes	0	23,340
33. Accrued Interest Payable	0	6,056
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	231,556	231,556
37. Other Current Liabilities (specify):	57,520	57,520
38. Total Current Liabilities	805,015	834,411
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,887,481
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	831,071	-17,057
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	831,071	1,870,424
46.Total Liabilities	1,636,086	2,704,835
47.Total Equity	-975,042	-883,914
48.Total Liabilities and Equity	661,044	1,820,921

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,908,855
2. Discounts and Allowances for all Levels	-166,303
Subtotal - Inpatient Care	2,742,552
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	326,893
7. Oxygen	349
Subtotal - Anciliary Revenue	327,242
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,647
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	66,959
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	5,522
21. Other Medical Services	17,241
22. Laundry	0
Subtotal - Other Operating Revenue	91,369
24. Contributions	0
25. Interest and Other Investments Income	-63
Subtotal - Non-Operating Revenue	-63
27. Other Revenue (specify):	4,358
28. Other Revenue (specify):	11,443
Subtotal - Other Revenue	15,801
30. Total Revenue	3,176,901
31. General Services	489,420
32. Health Care	1,165,991
33. General Administration	505,444
34. Ownership	259,720
35. Special Cost Centers	212,799
35. Provider Participation Fee	147,067
37. Other	0
40. Total Expenses	2,780,441
41. Income Before Income Taxes	396,460
42. Income Taxes	0
43. Net Income or Loss for the Year	396,460