

		FOR BHF USE					

LL1

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

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

<p>I. IDPH License ID Number: <u>0050591</u></p> <p>Facility Name: <u>Flanagan Rehab & HCC</u></p> <p>Address: <u>201 East Falcon Hwy</u> <u>Flanagan</u> <u>61740</u> <small>Number City Zip Code</small></p> <p>County: <u>Livingston</u></p> <p>Telephone Number: <u>815-796-2267</u> Fax # <u>815-796-4434</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/1/2007</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Flanagan Rehab & HCC

0050591 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,480	4,756	1,562	14,798	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		365	101	466	12
13	DD 16 OR LESS					13
14	TOTALS	8,480	5,121	1,663	15,264	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.76%

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

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

Meals on Wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/7/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 43 and days of care provided 1,461

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	145,981	8,480		154,461		154,461	5,135	159,596		1
2	Food Purchase		126,767		126,767		126,767	(9,582)	117,185		2
3	Housekeeping	84,379	17,390		101,769		101,769	31	101,800		3
4	Laundry	22,052	3,720		25,772		25,772		25,772		4
5	Heat and Other Utilities			72,170	72,170		72,170	193	72,363		5
6	Maintenance	38,775	8,291	18,329	65,395		65,395	1,931	67,326		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	291,187	164,648	90,499	546,334		546,334	(2,292)	544,042		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800	18	4,818		9
10	Nursing and Medical Records	705,993	54,966	98,666	859,625		859,625	(220)	859,405		10
10a	Therapy			232,097	232,097		232,097		232,097		10a
11	Activities	25,560	148	991	26,699		26,699	(2,631)	26,699		11
12	Social Services	37,408			37,408		37,408		37,408		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	768,961	55,114	336,554	1,160,629		1,160,629	(2,833)	1,160,427		16
	C. General Administration										
17	Administrative			201,400	201,400		201,400	(135,143)	66,257		17
18	Directors Fees										18
19	Professional Services			5,920	5,920		5,920	17,308	23,228		19
20	Dues, Fees, Subscriptions & Promotions			5,854	5,854		5,854	670	6,524		20
21	Clerical & General Office Expenses	10,533	3,139	9,709	23,381		23,381	57,133	80,514		21
22	Employee Benefits & Payroll Taxes			135,012	135,012		135,012	13,236	148,248		22
23	Inservice Training & Education							23	23		23
24	Travel and Seminar							20	20		24
25	Other Admin. Staff Transportation			8,943	8,943		8,943	3,118	12,061		25
26	Insurance-Prop.Liab.Malpractice			25,514	25,514		25,514	450	25,964		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	10,533	3,139	392,352	406,024		406,024	(43,185)	362,839		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,070,681	222,901	819,405	2,112,987		2,112,987	(48,310)	2,067,308		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

Flanagan Rehab & HCC

#0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			55,608	55,608		55,608	(1,084)	54,524			30
31	Amortization of Pre-Op. & Org.							5,569	5,569			31
32	Interest			66,233	66,233		66,233	13,924	80,157			32
33	Real Estate Taxes			33,890	33,890		33,890	179	34,069			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,990	21,990		21,990	759	22,749			35
36	Other (specify):*											36
37	TOTAL Ownership			177,721	177,721		177,721	19,347	197,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,468		41,468		41,468		41,468			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,186	107,186		107,186		107,186			42
43	Other (specify):*		245	27,426	27,671		27,671	(27,671)				43
44	TOTAL Special Cost Centers		41,713	134,612	176,325		176,325	(27,671)	148,654			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,070,681	264,614	1,131,738	2,467,033		2,467,033	(56,634)	2,413,030			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 Flanagan Rehab & HCC

0050591

Report Period Beginning: 1/1/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,567)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,930)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,652)	30		9
10	Interest and Other Investment Income	(904)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(392)	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	(15,097)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		43		24
25	Fund Raising, Advertising and Promotional	(824)	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	(12,645)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,011)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,623)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (11,623)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (56,634)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Flanagan Rehab & HCC

ID# 0050591

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (3,016)	43	1
2	X-Rays-Part A	(544)	43	2
3	Disallowed Special Events	77	43	3
4	Offset Miscellaneous Vending Revenue	(1,056)	2	4
5	Offset Miscellaneous Nursing Supplies Revenue	(235)	10	5
6	Offset Transportation Revenue	(2,631)	11	6
7	Pet Expense	(700)	43	7
8	Disallowed Chamber of Commerce Dues	(275)	20	8
9	Offset Cable TV Revenue		43	9
10	Disallowed Marketing Expense	(245)	43	10
11	Offset Meals on Wheels Revenue	(4,020)	2	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		(12,645)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,237	\$ 2,237	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	54	54	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	11	11	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	151	151	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	849	849	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	18	18	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A TherUy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,929	1,929	12
13	V							13
14	Total		\$			\$ 5,250	\$ * 5,250	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 107	\$	107	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	25,178		25,178	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,145		1,145	17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	13		13	18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	8		8	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,036		2,036	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	359		359	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,056		2,056	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,308		1,308	24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	101		101	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	517		517	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		\$			\$ 32,828	\$ *	32,828	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		18
19	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		20
21	V	9 Medical Director		Petersen Health Network, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	11,022	11,022	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	803	803	27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	145	145	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%	1,117	1,117	29
30	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		30
31	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		31
32	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		34
35	V	30 Depreciation		Petersen Health Network, LLC	100.00%	373	373	35
36	V	31 Amortization of Pre-Op. & Org.		Petersen Health Network, LLC	100.00%	5,569	5,569	36
37	V	32 Interest		Petersen Health Network, LLC	100.00%	13,335	13,335	37
38	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		38
39	Total		\$			\$ 32,364	\$ *	32,364 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,898	\$	2,898	15
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	7		7	16
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	20		20	17
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	42		42	18
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,082		1,082	19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			20
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0			21
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	14		14	22
23	V	10A TherUy		Petersen Health Care Management, Inc.	100.00%	0			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			24
25	V	17 Administrative	201,400	Petersen Health Care Management, Inc.	100.00%	66,257		(135,143)	25
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	4,357		4,357	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	35		35	27
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	31,810		31,810	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,974		10,974	29
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	10		10	30
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	12		12	31
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,082		1,082	32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	91		91	33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			34
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	139		139	35
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	185		185	36
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	78		78	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	242		242	38
39	Total		\$ 201,400			\$ 119,335	\$ *	(82,065)	39

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

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	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 Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Flanagan Rehab & HCC # 0050591 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6	N/A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,572,338	77	\$ 231,473	\$ 220,289	15,193	\$ 2,237	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	15,193	54	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	15,193	11	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	15,193	151	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	15,193	849	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	15,193	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	15,193	18	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	15,193	1	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	15,193	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	15,193	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	15,193	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	15,193	1,929	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	15,193	107	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	15,193	25,178	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	15,193	1,145	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	15,193	13	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	15,193	8	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	15,193	2,036	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	15,193	359	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	15,193	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	15,193	2,056	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	15,193	1,308	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	15,193	101	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	15,193	517	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 38,078	25

Facility Name & ID Number Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	247,554	14		15,193		1
2	2	Food	Resident Days	247,554	14		15,193		2
3	3	Housekeeping	Resident Days	247,554	14		15,193		3
4	5	Utilities	Resident Days	247,554	14		15,193		4
5	6	Maintenance	Resident Days	247,554	14		15,193		5
6	7	Mgmt. Allocation of Benefits	Resident Days	247,554	14		15,193		6
7	9	Medical Director	Resident Days	247,554	14		15,193		7
8	10	Nursing and Medical Records	Resident Days	247,554	14		15,193		8
9	10A	Therapy	Resident Days	247,554	14		15,193		9
10	15	Mgmt. Allocation of Benefits	Resident Days	247,554	14		15,193		10
11	17	Administrative	Resident Days	247,554	14		15,193		11
12	19	Professional Services	Resident Days	247,554	14	192,241	15,193	11,022	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	247,554	14	14,000	15,193	803	13
14	21	Clerical and General Office	Resident Days	247,554	14	2,534	15,193	145	14
15	22	Employee Benefits and Payroll Tax	Resident Days	247,554	14	19,477	15,193	1,117	15
16	23	Inservice Training & Education	Resident Days	247,554	14		15,193		16
17	24	Travel and Seminar	Resident Days	247,554	14		15,193		17
18	25	Other Admin. Staff Transport.	Resident Days	247,554	14		15,193		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	247,554	14		15,193		19
20	27	Mgmt. Allocation of Benefits	Resident Days	247,554	14		15,193		20
21	30	Depreciation	Resident Days	247,554	14	6,500	15,193	373	21
22	31	Amortization of Pre-Op. & Org.	Resident Days	247,554	14	97,144	15,193	5,569	22
23	32	Interest	Resident Days	247,554	14	232,596	15,193	13,335	23
24	33	Real Estate Taxes	Resident Days	247,554	14		15,193		24
25	TOTALS					\$ 564,492	\$	\$ 32,364	25

Facility Name & ID Number Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,572,338	77	\$ 299,961	\$ 294,997	15,193	\$ 2,898	1
2	2	Food	Resident Days	1,572,338	77	675		15,193	7	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	15,193	20	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		15,193	42	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	15,193	1,082	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			15,193		6
7	9	Medical Director	Resident Days	1,572,338	77			15,193		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		15,193	14	8
9	10A	TherUy	Resident Days	1,572,338	77			15,193		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			15,193		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	15,193	66,257	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		15,193	4,357	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		15,193	35	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	15,193	31,810	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		15,193	10,974	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		15,193	10	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		15,193	12	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		15,193	1,082	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		15,193	91	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			15,193		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		15,193	139	21
22	32	Interest	Resident Days	1,572,338	77	19,133		15,193	185	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		15,193	78	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		15,193	242	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 119,335	25

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	The Private Bank		X	Mortgage	Varies	11/1/09	1,239,044	\$ 764,181	10/31/2014	Varies	\$ 66,233						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 1,239,044	\$ 764,181			\$ 66,233						
B. Non-Facility Related*																	
10										Home Office Allocation-PHCM	185						
11										Interest Income Offset	(904)						
12										Home Office Allocation-PHC	1,308						
13										Home Office Allocation-PHN	13,335						
14	TOTAL Non-Facility Related						\$	\$			\$ 13,924						
15	TOTALS (line 9+line14)						\$ 1,239,044	\$ 764,181			\$ 80,157						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.				\$	38,220	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2013		\$	35,522	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,698)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	36,588	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND	\$	For	Tax Year.			
					Home Office Allocation	179
				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	34,069	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	<u>28,062</u>	8	FOR BHF USE ONLY		
	2010	<u>38,254</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013	\$
	2011	<u>37,659</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$
	2012	<u>37,107</u>	11	15	LESS REFUND FROM LINE 6	\$
	2013	<u>35,522</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$
Accrual based on prior year tax bill.						

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Flanagan Rehab & HCC COUNTY Livingston
 FACILITY IDPH LICENSE NUMBER 0050591
 CONTACT PERSON REGARDING THIS REPORT Mark Petersen
 TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-13-27-226-004</u>	<u>Long-Term Care Facility</u>	\$ <u>221.38</u>	\$ <u>221.38</u>
2. <u>13-13-27-201-015</u>	<u>Long-Term Care Facility</u>	\$ <u>92.94</u>	\$ <u>92.94</u>
3. <u>13-13-27-203-003</u>	<u>Long-Term Care Facility</u>	\$ <u>34,584.64</u>	\$ <u>34,584.64</u>
4. <u>13-13-27-201-017</u>	<u>Long-Term Care Facility</u>	\$ <u>292.22</u>	\$ <u>292.22</u>
5. <u>13-13-27-203-001</u>	<u>Long-Term Care Facility</u>	\$ <u>330.62</u>	\$ <u>330.62</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>35,521.80</u></u>	\$ <u><u>35,521.80</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Flanagan Rehab & HCC

0050591 Report Period Beginning:

1/1/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 5,569 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	<u>Facility</u>	<u>16,000</u>	<u>2007</u>	<u>\$ 30,000</u>	1
2					2
3	TOTALS	16,000		\$ 30,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	75	2007	1982	\$ 810,000	\$	25	\$ 32,400	\$ 32,400	\$ 198,450	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements	2007		10,000		15	667	667	4,769	9
10	Boiler	2010		8,200		15	546	546	2,457	10
11	A/C Unit	2012		5,146		15	344	344	860	11
12	Sewer Line Repair	2013		5,968		7	852	852	1,278	12
13	Air Conditioner	2013		4,344		15	290	290	435	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

*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 Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63					667		(667)	63
64					32,400		(32,400)	64
65					2,032		(2,032)	65
66								66
67					7,092	170	170	67
68					662	36	36	68
69								69
70		\$	\$		\$	\$	\$	70
TOTAL (lines 4 thru 69)		851,412	35,099		35,305	206	208,249	

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

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	\$ 168,567	\$ 2,255	\$ 16,857	\$ 14,602	5-10 yrs.	\$ 121,472	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,362	2,362			74
75	TOTALS	\$ 168,567	\$ 2,255	\$ 19,219	\$ 16,964		\$ 121,472	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)	\$ 1,049,979	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,354	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,524	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,170	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 329,721	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,607 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	\$ 822.05	\$ 10,142	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 10,142	21

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

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

Flanagan Rehab & HCC

0050591

Period Beginning 1/1/2014

Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 10,627
Dishwasher	658
Laundry Equipment	-
Copier	563
Home Office Allocation	759
	<u>12,607</u>

Facility Name & ID Number Flanagan Rehab & HCC # 0050591 Report Period Beginning: 1/1/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8			
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
			Units of Service			Units	Cost							
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,082	\$	91,227	\$	6,082	\$	91,227	1		
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,228		48,419		3,228		48,419	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10A(3)	hrs		6,163		92,451		6,163		92,451	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39(2)	# of prescripts					41,468			41,468	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			\$	15,473	\$	232,097	\$	41,468		15,473	\$	273,565	14

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

Facility Name & ID Number Flanagan Rehab & HCC# 0050591Report Period Beginning: 1/1/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 250,380	\$ 250,380	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>117,376</u>)	492,261	492,261	3
4	Supply Inventory (priced at _____)	6,680	6,680	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,193	27,193	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit & PPD Lease</u>	5,757	5,757	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 782,271	\$ 782,271	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000	30,000	13
14	Buildings, at Historical Cost	810,000	817,092	14
15	Leasehold Improvements, at Historical Cost	23,657	34,320	15
16	Equipment, at Historical Cost	168,567	168,567	16
17	Accumulated Depreciation (book methods)	(403,764)	(329,721)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>A/R-Prior Owner</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 638,460	\$ 720,258	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,420,731	\$ 1,502,529	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 420,396	\$ 420,396	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,328	62,328	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,182	9,182	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,588	36,588	32
33	Accrued Interest Payable	3,065	3,065	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	38,256	38,256	36
37	<u>Accrued Management Fees</u>	115,599	115,599	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 685,414	\$ 685,414	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	764,181	764,181	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	(5,423)	(5,423)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 758,758	\$ 758,758	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,444,172	\$ 1,444,172	46
47	TOTAL EQUITY (page 18, line 24)	\$ (23,441)	\$ 58,357	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,420,731	\$ 1,502,529	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,499	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 20,499	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(43,940)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (43,940)	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)	\$ (23,441)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,167,930	1
2	Discounts and Allowances for all Levels	(254,397)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,913,533	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,377	6
7	Oxygen	457	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 402,834	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	4,567	14
15	Telephone, Television and Radio	520	15
16	Rental of Facility Space		16
17	Sale of Drugs	84,150	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,424	20
21	Other Medical Services	4,219	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 97,880	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	904	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 904	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Vending Revenue	5,311	28
28a	Transportation Revenue & Meals on Wheels	2,631	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,942	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,423,093	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	546,334	31
32	Health Care	1,160,629	32
33	General Administration	406,024	33
B. Capital Expense			
34	Ownership	177,721	34
C. Ancillary Expense			
35	Special Cost Centers	69,139	35
36	Provider Participation Fee	107,186	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,467,033	40
41	Income before Income Taxes (line 30 minus line 40)**	(43,940)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (43,940)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,265,598	44
45	Private Pay - Net Inpatient Revenue	427,532	45
46	Medicare - Net Inpatient Revenue	224,719	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(4,316)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,913,533	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 Flanagan Rehab & HCC

0050591

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 72,096	\$ 34.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,965	6,182	163,638	26.47	3
4	Licensed Practical Nurses	4,112	4,188	95,456	22.79	4
5	CNAs & Orderlies	27,910	28,814	326,368	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,881	1,967	25,496	12.96	10
11	Social Service Workers	2,080	2,080	37,408	17.98	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,939	17.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,601	12,227	109,042	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,837	1,985	38,775	19.53	17
18	Housekeepers	9,366	9,640	84,379	8.75	18
19	Laundry	1,875	2,078	22,052	10.61	19
20	Administrator	2,080	2,080	66,257	31.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	958	958	10,533	11.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	1,970	2,073	48,499	23.39	33
34	TOTAL (lines 1 - 33)	75,795	78,432	\$ 1,136,938 *	\$ 14.50	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 4,800	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,187	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,987		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	796 \$ 26,508	L10, C3	50
51	Licensed Practical Nurses	2,213 68,326	L10, C3	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	3,009 \$ 94,834		53

Flanagan Rehab & HCC

0050591

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,968	2,068	48,435	23.42
Transportation	3	5	64	12.80
TOTAL	<u>1,970</u>	<u>2,073</u>	<u>48,499</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gregory Green	Administrator	0	\$ 66,257	Workers' Compensation Insurance	\$ 36,527	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	24,155	Advertising: Employee Recruitment	144	
				FICA Taxes	74,912	Health Care Worker Background Check		
				Employee Health Insurance	(9,181)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	113.5 1,135	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	320	
				Employee Relations	7,946	Miscellaneous Dues & Subscriptions	275	
				Employee Retirement	653	Home Office Allocation	945	
				Home Office Allocation	13,236			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 66,257					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 201,400				Less: Public Relations Expense (275)	
							Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 201,400					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 4,930				Out-of-State Travel	\$
Frontier	Computer Services		970					
Livingston County Clerk	Filing Fees		20				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	20
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 5,920				TOTAL \$ 20	

* Attach copy of IMRF notifications

**See instructions.

Flanagan Rehab & HCC

0050591

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,920

Home Office Allocation

Lexis Nexis	Legal	6
GoffWilson	Legal	354
Illinois Secretary of State	Legal	32
Bank of America	Legal	107
Healthcare Resources International	Legal	64
Miscellaneous	Legal	14
Addy, Bush	Legal	9
Hall, Rustom, and Fritz	Legal	11
Black, Hedin, Ballard	Legal	19
SmithAmundsen	Legal	19
Applegate and Thorne	Legal	1,251
Healthcare Resources	Legal	757
ETS Environmental	Legal	69
IL Secretary of State	Legal	14
CliftonLarson Allen	Accountants	753
Ginoli & Co.	Accountants	2,000
Wells Fargo	Accountants	1,045
Miscellaneous	Computer Services	14
Odessian LLC	Computer Services	4
Optimizer	Computer Services	30
Allpayer Exchange	Computer Services	9
CCH	Computer Services	16
Prism Software	Computer Services	48
Macquarie Technology Services	Computer Services	42
Advanced Answers on Demand	Computer Services	2,232
Stratus Networks	Computer Services	294
Kemper Technology	Computer Services	870

AT&T	Computer Services	3
Ability Network	Computer Services	337
Barracuda	Computer Services	77
CIAN	Computer Services	92
Comcast	Computer Services	23
Emdeon	Computer Services	60
Charter Communications	Computer Services	4
E-Health Data Solutions	Computer Services	212
Crawford County Title Co.	Other Prof Fees	4
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	26
All Scripts	Other Prof Fees	18
Miscellaneous	Other Prof Fees	2
Marotta Gund Budd Derza	Other Prof Fees	6,135
Polsinelli	Other Prof Fees	229
Total (agree to Schedule V, line 19, column 8)		<u>23,228</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Flanagan Rehab & HCC# 0050591Report Period Beginning: 1/1/14Ending: 12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,539 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 107,186
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. \$ 4,567
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adquate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.