

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr

0053066 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	<u>12</u>	Skilled (SNF)	<u>12</u>	<u>4,380</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,820</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	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	<u>803</u>	<u>60</u>	<u>876</u>	<u>1,739</u>	8
9	SNF/PED					9
10	ICF	<u>5,201</u>	<u>3,147</u>	<u>19</u>	<u>8,367</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,004</u>	<u>3,207</u>	<u>895</u>	<u>10,106</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 34.61%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 876

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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	107,341	8,044		115,385		115,385	3,416	118,801		1
2	Food Purchase		70,486		70,486		70,486	(1,028)	69,458		2
3	Housekeeping	64,171	12,973		77,144		77,144	21	77,165		3
4	Laundry	16,619	5,269		21,888		21,888		21,888		4
5	Heat and Other Utilities			67,487	67,487		67,487	128	67,615		5
6	Maintenance	28,784	13,847	11,831	54,462		54,462	1,285	55,747		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	216,915	110,619	79,318	406,852		406,852	3,822	410,674		8
	B. Health Care and Programs										
9	Medical Director			16,000	16,000		16,000	12	16,012		9
10	Nursing and Medical Records	499,683	48,213	3,277	551,173		551,173	9	551,182		10
10a	Therapy			97,110	97,110		97,110		97,110		10a
11	Activities	30,400	501	437	31,338		31,338	(3,460)	27,878		11
12	Social Services	4,783			4,783		4,783		4,783		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	534,866	48,714	116,824	700,404		700,404	(3,439)	696,965		16
	C. General Administration										
17	Administrative			164,000	164,000		164,000	(97,862)	66,138		17
18	Directors Fees										18
19	Professional Services			10,912	10,912		10,912	42,694	53,606		19
20	Dues, Fees, Subscriptions & Promotions			5,221	5,221		5,221	178	5,399		20
21	Clerical & General Office Expenses	27,157	2,849	10,622	40,628		40,628	37,765	78,393		21
22	Employee Benefits & Payroll Taxes			128,274	128,274		128,274	8,946	137,220		22
23	Inservice Training & Education							15	15		23
24	Travel and Seminar							13	13		24
25	Other Admin. Staff Transportation			7,680	7,680		7,680	2,074	9,754		25
26	Insurance-Prop.Liab.Malpractice			27,390	27,390		27,390	300	27,690		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	27,157	2,849	354,099	384,105		384,105	(5,877)	378,228		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	778,938	162,182	550,241	1,491,361		1,491,361	(5,494)	1,485,867		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 Shelbyville Reh & Hlth C Ctr

#0053066

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			47,628	47,628		47,628	3,983	51,611			30
31	Amortization of Pre-Op. & Org.							482	482			31
32	Interest			8,797	8,797		8,797	9,159	17,956			32
33	Real Estate Taxes			31,162	31,162		31,162	119	31,281			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,365	25,365		25,365	505	25,870			35
36	Other (specify):*											36
37	TOTAL Ownership			112,952	112,952		112,952	14,248	127,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,640		35,640		35,640		35,640			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,193	105,193		105,193		105,193			42
43	Other (specify):*	24,576	1,120	117,522	143,218		143,218	(143,218)				43
44	TOTAL Special Cost Centers	24,576	36,760	222,715	284,051		284,051	(143,218)	140,833			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	803,514	198,942	885,908	1,888,364		1,888,364	(134,464)	1,753,900			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 Shelbyville Reh & Hlth C Ctr

0053066

Report Period Beginning: 1/1/14

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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	(1,068)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,462	30		9
10	Interest and Other Investment Income	(536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	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	(61,830)	43		18
19	Entertainment				19
20	Contributions	(280)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	43		24
25	Fund Raising, Advertising and Promotional	(28,295)	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	(8,349)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,962)		\$	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)	12,498	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,498		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (134,464)		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

Shelbyville Reh & Hlth C Ctr

ID# 0053066

Report Period Beginning: 1/1/14

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,796)	43	1
2	X-Rays-Part A	(1,267)	43	2
3	Resident Flowers	(353)	43	3
4	Offset Transportation Revenue	(3,460)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(142)	21	5
6	Disallowed Special Events	(331)	43	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
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		(8,349)	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%	\$ 1,488	\$ 1,488	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	36	36	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	8	8	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	100	100	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	565	565	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%	12	12	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,283	1,283	12
13	V							13
14	Total		\$			\$ 3,492	\$ * 3,492	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 71	\$	71	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	16,748		16,748	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	761		761	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	8		8	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5		5	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,354		1,354	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	239		239	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,368		1,368	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	870		870	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	67		67	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	344		344	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		\$			\$ 21,835	\$ *	21,835	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 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	12 Social Services		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%	38,513	38,513	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	84	84	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%	886	886	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	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,060	1,060	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	4,428	4,428	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		\$			\$ 44,971	\$ *	44,971	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%	\$ 1,928	\$ 1,928
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	13	13
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	28	28
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	720	720
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	9	9
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	164,000	Petersen Health Care Management, Inc.	100.00%	66,138	(97,862)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	2,898	2,898
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	23	23
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	21,159	21,159
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,299	7,299
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	7	7
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	8	8
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	720	720
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	61	61
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	93	93
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	123	123
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	52	52
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	161	161
39	Total		\$ 164,000			\$ 101,444	\$ * (62,556)

* 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 & Wellness, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health & Wellness, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health & Wellness, LLC	100.00%	0		17
18	V	5 Utilities		Petersen Health & Wellness, LLC	100.00%	0		18
19	V	6 Maintenance		Petersen Health & Wellness, LLC	100.00%	0		19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		20
21	V	9 Medical Director		Petersen Health & Wellness, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health & Wellness, LLC	100.00%	0		22
23	V	10A Therapy		Petersen Health & Wellness, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Health & Wellness, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Health & Wellness, LLC	100.00%	0		26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health & Wellness, LLC	100.00%	0		27
28	V	21 Clerical and General Office		Petersen Health & Wellness, LLC	100.00%	0		28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health & Wellness, LLC	100.00%	0		29
30	V	23 Inservice Training & Education		Petersen Health & Wellness, LLC	100.00%	0		30
31	V	24 Travel and Seminar		Petersen Health & Wellness, LLC	100.00%	0		31
32	V	25 Other Admin. Staff Transport.		Petersen Health & Wellness, LLC	100.00%	0		32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health & Wellness, LLC	100.00%	0		33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		34
35	V	30 Depreciation		Petersen Health & Wellness, LLC	100.00%	0		35
36	V	31 Amortization of Pre-Op. & Org.		Petersen Health & Wellness, LLC	100.00%	482	482	36
37	V	32 Interest		Petersen Health & Wellness, LLC	100.00%	4,274	4,274	37
38	V	33 Real Estate Taxes		Petersen Health & Wellness, LLC	100.00%	0		38
39	Total		\$			\$ 4,756	\$ * 4,756	39

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

Facility Name & ID Number

Shelbyville Reh & Hlth C Ctr

0053066

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

Shelbyville Reh & Hlth C Ctr

0053066

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

Shelbyville Reh & Hlth C Ctr

0053066

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

Shelbyville Reh & Hlth C Ctr

0053066

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 Shelbyville Reh & Hlth C Ctr # 0053066 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 Shelbyville Reh & Hlth C Ctr

0053066

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	10,106	\$ 1,488	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	10,106	36	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	10,106	8	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	10,106	100	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	10,106	565	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	10,106	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	10,106	12	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	10,106	0	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	10,106	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	10,106	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	10,106	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	10,106	1,283	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	10,106	71	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	10,106	16,748	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	10,106	761	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	10,106	8	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	10,106	5	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	10,106	1,354	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	10,106	239	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	10,106	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	10,106	1,368	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	10,106	870	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	10,106	67	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	10,106	344	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 25,327	25

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr

0053066

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 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

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	314,070	19		10,106		1
2	2	Food	Resident Days	314,070	19		10,106		2
3	3	Housekeeping	Resident Days	314,070	19		10,106		3
4	4	Laundry	Resident Days	314,070	19		10,106		4
5	5	Utilities	Resident Days	314,070	19		10,106		5
6	6	Maintenance	Resident Days	314,070	19		10,106		6
7	7	Mgmt. Allocation of Benefits	Resident Days	314,070	19		10,106		7
8	10	Nursing and Medical Records	Resident Days	314,070	19		10,106		8
9	12	Social Services	Resident Days	314,070	19		10,106		9
10	17	Administrative	Resident Days	314,070	19		10,106		10
11	19	Professional Services	Resident Days	314,070	19	1,618,178	10,106	38,513	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	314,070	19	3,514	10,106	84	12
13	21	Clerical and General Office	Resident Days	314,070	19		10,106		13
14	22	Employee Benefits & Payroll	Resident Days	314,070	19	37,245	10,106	886	14
15	23	Inservice Training & Education	Resident Days	314,070	19		10,106		15
16	24	Travel and Seminar	Resident Days	314,070	19		10,106		16
17	25	Other Admin. Staff Transport.	Resident Days	314,070	19		10,106		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	314,070	19		10,106		18
19	27	Mgmt. Allocation of Benefits	Resident Days	314,070	19		10,106		19
20	30	Depreciation	Resident Days	314,070	19	44,535	10,106	1,060	20
21	32	Interest	Resident Days	314,070	19	186,049	10,106	4,428	21
22	33	Real Estate Taxes	Resident Days	314,070	19		10,106		22
23	34	Rent-Facility and Grounds	Resident Days	314,070	19		10,106		23
24	35	Rent-Equipment & Vehicles	Resident Days	314,070	19		10,106		24
25	TOTALS					\$ 1,889,521	\$	\$ 44,971	25

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr

0053066 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	10,106	\$ 1,928	1
2	2	Food	Resident Days	1,572,338	77	675		10,106	4	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	10,106	13	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		10,106	28	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	10,106	720	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			10,106		6
7	9	Medical Director	Resident Days	1,572,338	77			10,106		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		10,106	9	8
9	10A	Therapy	Resident Days	1,572,338	77			10,106		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			10,106		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	10,106	66,138	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		10,106	2,898	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		10,106	23	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	10,106	21,159	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		10,106	7,299	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		10,106	7	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		10,106	8	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		10,106	720	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		10,106	61	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			10,106		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		10,106	93	21
22	32	Interest	Resident Days	1,572,338	77	19,133		10,106	123	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		10,106	52	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		10,106	161	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 101,444	25

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr

0053066 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 & Wellness, 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	43,482	11		10,106		1
2	2	Food	Resident Days	43,482	11		10,106		2
3	3	Housekeeping	Resident Days	43,482	11		10,106		3
4	5	Utilities	Resident Days	43,482	11		10,106		4
5	6	Maintenance	Resident Days	43,482	11		10,106		5
6	7	Mgmt. Allocation of Benefits	Resident Days	43,482	11		10,106		6
7	9	Medical Director	Resident Days	43,482	11		10,106		7
8	10	Nursing and Medical Records	Resident Days	43,482	11		10,106		8
9	10A	Therapy	Resident Days	43,482	11		10,106		9
10	15	Mgmt. Allocation of Benefits	Resident Days	43,482	11		10,106		10
11	17	Administrative	Resident Days	43,482	11		10,106		11
12	19	Professional Services	Resident Days	43,482	11		10,106		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	43,482	11		10,106		13
14	21	Clerical and General Office	Resident Days	43,482	11		10,106		14
15	22	Employee Benefits and Payroll Tax	Resident Days	43,482	11		10,106		15
16	23	Inservice Training & Education	Resident Days	43,482	11		10,106		16
17	24	Travel and Seminar	Resident Days	43,482	11		10,106		17
18	25	Other Admin. Staff Transport.	Resident Days	43,482	11		10,106		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	43,482	11		10,106		19
20	27	Mgmt. Allocation of Benefits	Resident Days	43,482	11		10,106		20
21	30	Depreciation	Resident Days	43,482	11		10,106		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	43,482	11	7,964	10,106	482	22
23	32	Interest	Resident Days	43,482	11	70,629	10,106	4,274	23
24	33	Real Estate Taxes	Resident Days	43,482	11		10,106		24
25	TOTALS					\$ 78,593	\$	\$ 4,756	25

Facility Name & ID Number

Shelbyville Reh & Hlth C Ctr

0053066

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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 400,000	\$ 178,194	12/31/14	Varies	\$ 8,797	1					
2												2					
3									Interest Income Offset		(536)	3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 400,000	\$ 178,194			\$ 8,261	9					
B. Non-Facility Related*																	
10									Home Office Allocation-PHC		870	10					
11									Home Office Allocation-PHO		4,428	11					
12									Home Office Allocation-PHCM		123	12					
13									Home Office Allocation-PHW		4,274	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 9,695	14					
15	TOTALS (line 9+line14)						\$ 400,000	\$ 178,194			\$ 17,956	15					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.			\$	<u>31,980</u>	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		\$	<u>31,102</u>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	(878)	3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>32,040</u>	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.				119															
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.			\$	<u>31,281</u>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>29,313</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>29,860</u>	9																
	2011	<u>30,116</u>	10																
	2012	<u>31,046</u>	11																
	2013	<u>31,102</u>	12																
<u>Accrual based on prior year tax bill.</u>																			

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.

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 Shelbyville Reh & Hlth C Ctr

0053066 Report Period Beginning:

1/1/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,099 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: 188,175 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 482 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>80,150</u>	<u>2005</u>	<u>\$ 47,250</u>	1
2					2
3	TOTALS	80,150		\$ 47,250	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	80	2005	1971	\$ 855,750	\$	25	\$ 34,230	\$ 34,230	\$ 325,185	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements	2005		15,000		15	1,000	1,000	9,500	9
10	Sidewalks	2006		6,365		15	424	424	3,604	10
11	Water Heater	2006		6,609		10	661	661	4,955	11
12	Building Repair (Wind Damage)	2007		4,308		15	287	287	2,153	12
13	Sprinkler Installation	2008		5,990		7	856	856	5,564	13
14	Sprinkler System Repair	2009		7,455		7	1,065	1,065	5,858	14
15	Dry Pipe Valve Repair	2010		3,869		7	552	552	2,484	15
16	Sprinkler Line Repair	2010		4,106		7	586	586	2,637	16
17	Sprinkler Replacement	2011		17,599		15	1,174	1,174	3,522	17
18	Water Heater	2013		5,850		7	836	836	1,254	18
19	Sidewalks	2013		4,850		15	324	324	486	19
20	Nurse's Station Construction	2013		27,007		25	1,080	1,080	1,620	20
21	Compressor and Piping Repair	2014		5,741		7	820	820	820	21
22	Roof Repair	2014		2,556		7	274	274	274	22
23	Water Heater	2014		5,844		7	209	209	209	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 Shelbyville Reh & Hlth C Ctr

0053066

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					1,424		(1,424)	63				
64					34,256		(34,256)	64				
65					7,948		(7,948)	65				
66								66				
67			4,718			113	113	67				
68			440			24	24	68				
69								69				
70		\$	984,057	\$	43,628	\$	44,515	\$	887	\$	370,125	70

**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	\$ 41,154	\$ 3,404	\$ 4,116	\$ 712	5-10 yrs.	\$ 20,531	71
72	Current Year Purchases	4,173	596	596		10 yrs.	596	72
73	Fully Depreciated Assets	181,719					181,719	73
74	Home Office Allocation			2,384	2,384			74
75	TOTALS	\$ 227,046	\$ 4,000	\$ 7,096	\$ 3,096		\$ 202,846	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)	\$ 1,258,353	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,628	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,611	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,983	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 572,971	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 Shelbyville Reh & Hlth C Ctr

0053066

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: \$ 19,510 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			\$ <u>578.17</u>	\$ <u>6,360</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>578.17</u>	\$ <u>6,360</u>	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.

Shelbyville Reh & Hlth C Ctr

0053066

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	\$ 12,695
Dishwasher	662
Laundry Equipment	59
Copier	5,589
Home Office Allocation	505
	<u>19,510</u>

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr # 0053066 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? <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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$	2,027	\$ 30,400	\$	2,027	\$ 30,400	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		734	11,005		734	11,005	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		3,714	55,705		3,714	55,705	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				35,640		35,640	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			\$	6,474	\$ 97,110	\$ 35,640	6,474	\$ 132,750	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 Shelbyville Reh & Hlth C Ctr

0053066

Report Period Beginning: 1/1/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 91,638	\$ 91,638	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>76,314</u>)	298,297	298,297	3
4	Supply Inventory (priced at)	6,592	6,592	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,975	28,975	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(23,957)	(23,957)	8
9	Other(specify): <u>Prepaid Expenses</u>	161	161	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 401,706	\$ 401,706	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,615	47,250	13
14	Buildings, at Historical Cost	855,750	860,468	14
15	Leasehold Improvements, at Historical Cost	95,174	123,589	15
16	Equipment, at Historical Cost	233,656	227,046	16
17	Accumulated Depreciation (book methods)	(568,249)	(572,971)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 684,946	\$ 685,382	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,086,652	\$ 1,087,088	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 587,546	\$ 587,546	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,818	40,818	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,596	22,596	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,040	32,040	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	24,754	24,754	36
37	<u>Accrued Management Fees</u>	285,310	285,310	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 993,064	\$ 993,064	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	178,194	178,194	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	(2,828)	(2,828)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 175,366	\$ 175,366	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,168,430	\$ 1,168,430	46
47	TOTAL EQUITY(page 18, line 24)	\$ (81,778)	\$ (81,342)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,086,652	\$ 1,087,088	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 224,364	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(991)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 223,373	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(178,366)	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)	\$ (178,366)	17
	B. Transfers (Itemize):		
18	Transfer of Net Assets Due to Corporate Restructuring	(126,785)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (126,785)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (81,778)	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	\$ 1,564,799		1
2	Discounts and Allowances for all Levels	(103,454)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,461,345		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	172,318		6
7	Oxygen	422		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 172,740		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	1,068		14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	58,768		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray	5,014		20
21	Other Medical Services	6,925		21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 71,775		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	536		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 536		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28	Miscellaneous Revenue	3,460		28
28a	Transportation Revenue	142		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,602		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,709,998		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	406,852		31
32	Health Care	700,404		32
33	General Administration	384,105		33
B. Capital Expense				
34	Ownership	112,952		34
C. Ancillary Expense				
35	Special Cost Centers	178,858		35
36	Provider Participation Fee	105,193		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,888,364		40
41	Income before Income Taxes (line 30 minus line 40)**	(178,366)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (178,366)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 856,016	44
45	Private Pay - Net Inpatient Revenue	435,983	45
46	Medicare - Net Inpatient Revenue	176,273	46
47	Other-(specify) <u>Insurance Net Revenue</u>	(4,562)	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(2,365)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,461,345	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 Shelbyville Reh & Hlth C Ctr

0053066

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	1,789	1,789	52,229	\$ 29.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	9,787	10,366	194,571	18.77	4
5	CNAs & Orderlies	20,971	21,586	227,711	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,967	2,045	30,400	14.87	9
10	Activity Assistants					10
11	Social Service Workers	319	319	4,783	15.01	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,355	15.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,886	9,061	75,986	8.39	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	28,784	13.84	17
18	Housekeepers	6,641	6,940	64,171	9.25	18
19	Laundry	1,668	1,886	16,619	8.81	19
20	Administrator	2,080	2,080	66,138	31.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,836	1,996	27,157	13.61	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>	2,642	2,711	49,748	18.35	33
34	TOTAL (lines 1 - 33)	62,745	64,940	\$ 869,652 *	\$ 13.39	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 16,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,035	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	2 110	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 \$ 18,145		49

C. CONTRACT NURSES

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

Shelbyville Reh & Hlth C Ctr
0053066
Period Beginning
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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	1,036	1,084	25,172	23.22
Marketing	1,606	1,627	24,576	15.10
TOTAL	2,642	2,711	49,748	

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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,912
Home Office Allocation		
Lexis Nexis	Legal	3
GoffWilson	Legal	235
Illinois Secretary of State	Legal	22
Bank of America	Legal	71
Healthcare Resources International	Legal	43
Miscellaneous	Legal	9
Addy, Bush	Legal	6
Hall, Rustom, and Fritz	Legal	7
Black, Hedin, Ballard	Legal	12
SmithAmundsen	Legal	13
CliftonLarson Allen	Accountants	501
Ginoli & Co.	Accountants	1,075
Miscellaneous	Computer Services	10
Odessian LLC	Computer Services	3
Optimizer	Computer Services	20
Allpayer Exchange	Computer Services	6
CCH	Computer Services	11
Prism Software	Computer Services	32
Macquarie Technology Services	Computer Services	28
Advanced Answers on Demand	Computer Services	1,484
Stratus Networks	Computer Services	195
Kemper Technology	Computer Services	579
AT&T	Computer Services	2
Ability Network	Computer Services	224
Barracuda	Computer Services	51

CIAN	Computer Services	61
Comcast	Computer Services	16
Emdeon	Computer Services	40
Charter Communications	Computer Services	2
Crawford County Title Co.	Other Prof Fees	3
Better Banks	Other Prof Fees	2
David Budde	Other Prof Fees	17
All Scripts	Other Prof Fees	12
Miscellaneous	Other Prof Fees	2
Registered Agent Solutions	Other Prof Fees	7
MGBD	Other Prof Fees	37,890
Total (agree to Schedule V, line 19, column 8)		<u>53,606</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 Shelbyville Reh & Hlth C Ctr

0053066

Report Period Beginning:

1/1/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$398.46
- (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
- (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. \$ 2,977 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 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. \$ 105,193
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. \$ 1,068
- (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. \$ 3,460
- 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.