

Facility Name & ID Number Benton Rehabilitation & Health Care Center

0047407 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,455	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF			1,813	1,813	8
9	SNF/PED					9
10	ICF	12,089	1,722		13,811	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,089	1,722	1,813	15,624	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.89%

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 11 and days of care provided 1,502

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	109,413	9,420	801	119,634		119,634	2,910	122,544		1
2	Food Purchase		87,440		87,440		87,440	(9)	87,431		2
3	Housekeeping	71,203	10,058		81,261		81,261	34	81,295		3
4	Laundry	28,304	7,288		35,592		35,592		35,592		4
5	Heat and Other Utilities			68,639	68,639		68,639	289	68,928		5
6	Maintenance	30,842	8,573	18,074	57,489		57,489	1,694	59,183		6
7	Other (specify):* Home Off. Ben. All.							682	682		7
8	TOTAL General Services	239,762	122,779	87,514	450,055		450,055	5,600	455,655		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	512,152	41,789	2,569	556,510		556,510	44	556,554		10
10a	Therapy		43	212,910	212,953		212,953		212,953		10a
11	Activities		582	9	591		591		591		11
12	Social Services	48,690			48,690		48,690		48,690		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	560,842	42,414	225,088	828,344		828,344	44	828,388		16
	C. General Administration										
17	Administrative			178,000	178,000		178,000	(115,438)	62,562		17
18	Directors Fees										18
19	Professional Services			4,139	4,139		4,139	3,913	8,052		19
20	Dues, Fees, Subscriptions & Promotions			2,235	2,235		2,235	1,462	3,697		20
21	Clerical & General Office Expenses		2,884	5,308	8,192		8,192	30,132	38,324		21
22	Employee Benefits & Payroll Taxes			109,967	109,967		109,967	2,520	112,487		22
23	Inservice Training & Education							208	208		23
24	Travel and Seminar							24	24		24
25	Other Admin. Staff Transportation			3,284	3,284		3,284	2,607	5,891		25
26	Insurance-Prop.Liab.Malpractice			25,897	25,897		25,897	432	26,329		26
27	Other (specify):* Home Off. Ben. All.							11,820	11,820		27
28	TOTAL General Administration		2,884	328,830	331,714		331,714	(62,320)	269,394		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	800,604	168,077	641,432	1,610,113		1,610,113	(56,676)	1,553,437		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 Benton Rehabilitation & Health Care Center #0047407 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			70,923	70,923		70,923	4,183	75,106			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,739	77,739		77,739	20,242	97,981			32
33	Real Estate Taxes			17,116	17,116		17,116	36	17,152			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,593	16,593		16,593	400	16,993			35
36	Other (specify):*											36
37	TOTAL Ownership			182,371	182,371		182,371	24,861	207,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,137		82,137		82,137		82,137			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,683	36,683		36,683		36,683			42
43	Other (specify):* Non-allowable Cost		346	44,566	44,912		44,912	(44,912)				43
44	TOTAL Special Cost Centers		82,483	81,249	163,732		163,732	(44,912)	118,820			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	800,604	250,560	905,052	1,956,216		1,956,216	(76,727)	1,879,489			45

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

Benton Rehabilitation & Health Care Center

ID# 0047407

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (5,592)	43	1
2	X-Rays-Part A	(7,189)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(131)	21	3
4	Disallow Real Estate Tax penalties	(377)	33	4
5	Disallowed Special Events	(162)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,451)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 Attached Schedule 6E		See Attached Sch. 6E		

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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,910	\$ 2,910	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	34	34	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	289	289	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,694	1,694	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	682	682	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	44	44	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	178,000	Petersen Health Care, Inc.	100.00%	62,562	(115,438)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,225	3,225	12
13	V							13
14	Total		\$ 178,000			\$ 71,440	\$ * (106,560)	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%	\$ 799	\$	799	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	28,965		28,965	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	208		208	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	24		24	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,607		2,607	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	432		432	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,820		11,820	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,352		3,352	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,863		3,863	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	413		413	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	400		400	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		\$			\$ 52,883	\$ *	52,883	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%	688	688	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	663	663	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,298	1,298	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	2,520	2,520	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%	770	770	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	17,055	17,055	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		\$			\$ 22,994	\$ *	22,994	39

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	Mark Petersen	President	Administrative	100.00	180,265	0.59	0.99	Salary	\$ 1,985	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,985		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 Benton Rehabilitation & Health Care Center

0047407

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	15,624	\$ 2,910	1
2	2	Food	Resident Days	1,527,029	77	0	0	15,624	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	15,624	34	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	15,624	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	15,624	289	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	15,624	1,694	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	15,624	682	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	15,624	44	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	15,624	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	15,624	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	15,624	62,562	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	15,624	3,225	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	15,624	799	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	15,624	28,965	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	15,624	208	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	15,624	24	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	15,624	2,607	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	15,624	432	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	15,624	11,820	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	15,624	3,352	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	15,624	3,863	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	15,624	413	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	15,624	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	15,624	400	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 124,323	25

Facility Name & ID Number Benton Rehabilitation & Health Care Center

0047407

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	389,552	21	\$	15,624	\$	1
2	2	Food	Resident Days	389,552	21		15,624		2
3	3	Housekeeping	Resident Days	389,552	21		15,624		3
4	4	Laundry	Resident Days	389,552	21		15,624		4
5	5	Utilities	Resident Days	389,552	21		15,624		5
6	6	Maintenance	Resident Days	389,552	21		15,624		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21		15,624		7
8	10	Nursing and Medical Records	Resident Days	389,552	21		15,624		8
9	12	Social Services	Resident Days	389,552	21		15,624		9
10	17	Administrative	Resident Days	389,552	21		15,624		10
11	19	Professional Services	Resident Days	389,552	21	17,164	15,624	688	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534	15,624	663	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356	15,624	1,298	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830	15,624	2,520	14
15	23	Inservice Training & Education	Resident Days	389,552	21		15,624		15
16	24	Travel and Seminar	Resident Days	389,552	21		15,624		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21		15,624		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21		15,624		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21		15,624		19
20	30	Depreciation	Resident Days	389,552	21	19,207	15,624	770	20
21	32	Interest	Resident Days	389,552	21	425,239	15,624	17,055	21
22	33	Real Estate Taxes	Resident Days	389,552	21		15,624		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21		15,624		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21		15,624		24
25	TOTALS					\$ 573,330	\$	22,994	25

Facility Name & ID Number

Benton Rehabilitation & Health Care Center

0047407

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	\$ 1,600,000	\$ 1,533,808	12/31/13	Varies	\$ 77,739	1							
2												2							
3							Interest Income Offset				(676)	3							
4							Home Office Allocation-PHC				3,863	4							
5							Home Office Allocation-PHO				17,055	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 1,600,000	\$ 1,533,808			\$ 97,981	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,600,000	\$ 1,533,808			\$ 97,981	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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 2009 report.			\$	17,300	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.)	2009		\$	16,759	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$	(541)	3																				
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,280	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.				413																					
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.			\$	17,152	7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2005	<u>15,545</u>	8	FOR BHF USE ONLY <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">13</td> <td style="width: 75%;">FROM R. E. TAX STATEMENT FOR 2009</td> <td style="width: 10%; text-align: right;">\$</td> <td style="width: 10%;"></td> <td style="width: 5%; 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: right;">\$</td> <td></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: right;">\$</td> <td></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: right;">\$</td> <td></td> <td style="text-align: center;">16</td> </tr> </table>		13	FROM R. E. TAX STATEMENT FOR 2009	\$		13	14	PLUS APPEAL COST FROM LINE 5	\$		14	15	LESS REFUND FROM LINE 6	\$		15	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
13	FROM R. E. TAX STATEMENT FOR 2009	\$				13																			
14	PLUS APPEAL COST FROM LINE 5	\$				14																			
15	LESS REFUND FROM LINE 6	\$				15																			
16	AMOUNT TO USE FOR RATE CALCULATION	\$				16																			
	2006	<u>15,973</u>	9																						
	2007	<u>16,249</u>	10																						
	2008	<u>16,753</u>	11																						
	2009	<u>16,759</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,200 B. General Construction Type: Exterior Brick & Block Frame Masonry 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>122,404</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	122,404		\$ 54,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	73	2005	1968	\$ 959,500	\$	25	\$ 38,379	\$ 38,379	\$ 211,087
5									
6									
7									
8									
	Improvement Type**								
9	Original Land Improvements	2005		15,000		15	1,000	1,000	5,500
10	Smoke Alarms	2007		2,341		10	234	234	819
11	Interior Signage	2007		3,678		10	368	368	1,288
12	Canopy	2007		3,572		10	357	357	1,250
13	Air Compressor Repair	2009		2,958		7	423	423	634
14	Sprinkler System Replacement	2010		56,828		15	1,894	1,894	1,894
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				1,000			(1,000)	
31	Building Booked				38,405			(38,405)	
32	Building Improvement Booked				3,394			(3,394)	
33									
34	2010-Home Office Allocation-Building Improvements			7,510			180	180	
35	2010-Home Office Allocation-Land Improvements			701			39	39	
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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,052,088	\$ 42,799		\$ 42,874	\$ 75	\$ 222,472	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 200,570	\$ 27,897	\$ 28,210	\$ 313	7-10 yrs.	\$ 153,068	71
72	Current Year Purchases	2,386	227	119	(108)	10 yrs.	119	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,903	3,903			74
75	TOTALS	\$ 202,956	\$ 28,124	\$ 32,232	\$ 4,108		\$ 153,187	75

D. Vehicle Depreciation (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	2	
	Reference	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)	\$ 1,309,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,923	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,106	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,183	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 375,659	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 16,993 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

**Benton Rehabilitation & Health Care Center
0047407**

**Period Beginning 1/1/2010
Period End 12/31/2010**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 12,378
Dishwasher	758
Laundry Equipment	56
Copier	3,401
Home Office Allocation	400
	<u>16,993</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,904	\$ 88,556	\$	5,904	\$ 88,556	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,925	28,871		1,925	28,871	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,277	94,163	43	6,277	94,206	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				82,137		82,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			88	1,320		88	1,320	13
14	TOTAL			\$	14,194	\$ 212,910	\$ 82,180	14,194	\$ 295,090	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 **Benton Rehabilitation & Health Care Center**

0047407

Report Period Beginning: **1/1/2010**

Ending: **12/31/2010**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010** (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	\$ 2,276,081	\$ 2,276,081	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u>)	262,443	262,443	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,490	17,490	6
7	Other Prepaid Expenses	6,305	6,305	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Management Fees</u>	45,000	45,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,607,319	\$ 2,607,319	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	69,000	54,000	13
14	Buildings, at Historical Cost	959,500	967,010	14
15	Leasehold Improvements, at Historical Cost	69,376	85,078	15
16	Equipment, at Historical Cost	202,956	202,956	16
17	Accumulated Depreciation (book methods)	(358,351)	(375,659)	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)	\$ 942,481	\$ 933,385	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,549,800	\$ 3,540,704	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 329,584	\$ 329,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,663	14,663	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,059	10,059	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,280	17,280	32
33	Accrued Interest Payable	6,870	6,870	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	13,383	13,383	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 391,839	\$ 391,839	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,533,808	1,533,808	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,533,808	\$ 1,533,808	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,925,647	\$ 1,925,647	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,624,153	\$ 1,615,057	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,549,800	\$ 3,540,704	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,231,464	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,231,464	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	392,689	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)	\$ 392,689	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,624,153	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Benton Rehabilitation & Health Care Center**# **0047407**Report Period Beginning: **1/1/2010**Ending: **12/31/2010**

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,013,233	1
2	Discounts and Allowances for all Levels	(84,524)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,928,709	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	275,958	6
7	Oxygen	337	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 276,295	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	9	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	128,948	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,024	20
21	Other Medical Services	2,113	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 143,094	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 676	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	131	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,348,905	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	450,055	31
32	Health Care	828,344	32
33	General Administration	331,714	33
B. Capital Expense			
34	Ownership	182,371	34
C. Ancillary Expense			
35	Special Cost Centers	127,049	35
36	Provider Participation Fee	36,683	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,956,216	40
41	Income before Income Taxes (line 30 minus line 40)**	392,689	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 392,689	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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 **Benton Rehabilitation & Health Care Center**

0047407

Report Period Beginning: **1/1/2010**

Ending:

12/31/2010

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	1,793	1,793	\$ 41,385	\$ 23.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,047	2,205	41,144	18.66	3
4	Licensed Practical Nurses	7,796	8,028	131,022	16.32	4
5	CNAs & Orderlies	27,730	28,788	262,013	9.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,046	4,182	48,690	11.64	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,744	12.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,642	9,896	82,669	8.35	15
16	Dishwashers					16
17	Maintenance Workers	2,283	2,315	30,842	13.32	17
18	Housekeepers	7,991	8,254	71,203	8.63	18
19	Laundry	3,199	3,409	28,304	8.30	19
20	Administrator	2,080	2,080	60,577	29.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	36,588	17.59	33
34	TOTAL (lines 1 - 33)	72,767	75,110	\$ 861,181 *	\$ 11.47	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	Monthly	\$ 801	1(3)	35
36	Medical Director	Monthly	9,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,542	10(3)	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)		\$ 12,943		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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	
Ronald Slaviero	Administrator	0	\$ 60,577	Workers' Compensation Insurance	\$ 26,683	IDPH License Fee	\$	
				Unemployment Compensation Insurance	17,309	Advertising: Employee Recruitment	187	
				FICA Taxes	59,907	Health Care Worker Background Check		
				Employee Health Insurance	4,669	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	77	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	378	
				Employee Relations	906	Miscellaneous Dues & Subscriptions		
				Employee Retirement	440	IHCA Dues	900	
				Life Insurance	53	Home Office Allocation	1,462	
				Home Office Allocation	2,520			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,577	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 112,487		\$ 3,697		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 178,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 178,000				Seminar Expense	
							Home Office Allocation	24
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,139	TOTAL		\$	TOTAL	\$ 24

* Attach copy of IMRF notifications

**See instructions.

Benton Rehabilitation & Health Care Center

0047407

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,139

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	3
Healthcare Resources International	Legal	40
Ginoli & Company	Accountants	1,258
Bank of America	Accountants	125
Miscellaneous Vendors	Computer Services	19
VisionShare	Computer Services	172
Advanced Answers on Demand	Computer Services	1,078
Access 2 Go	Computer Services	175
Kemper Technology	Computer Services	149
MediFax	Computer Services	61
LogmeIn	Computer Services	44
Simple LTC	Computer Services	687
Optimizer Systems	Other Professional I	25
Clifton Gunderson	Other Professional I	77
Total (agree to Schedule V, line 19, column 8)		<u>8,052</u>

Facility Name & ID Number Benton Rehabilitation & Health Care Center# 0047407Report Period Beginning: 1/1/2010Ending: 12/31/2010**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. 900 IHCA
- (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. \$ 0 Line N/A
- (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. \$ 36,683
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? N/A 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. \$ 9
- (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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.