

		FOR BHF USE					

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**2015**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2015)**

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

<p><b>I. IDPH License ID Number:</b> <u>0047407</u></p> <p><b>Facility Name:</b> <u>Benton Rehab &amp; Hlth Care Ctr</u></p> <p><b>Address:</b> <u>1409 N Main St Bx847</u> <u>Benton</u> <u>62812</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Franklin</u></p> <p><b>Telephone Number:</b> <u>(618)435-2712</u> <b>Fax #</b> <u>(618)435-2105</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2015</u> to <u>12/31/2015</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

# 0047407 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		1,709	1,210	2,919	8
9	SNF/PED					9
10	ICF	9,172		92	9,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,172	1,709	1,302	12,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.82%

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 11 and days of care provided 1,210

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: 12/31/2015 Fiscal Year: 12/31/2015

\* 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
	<b>A. General Services</b>										
1	Dietary	113,613	6,560	2,084	122,257		122,257	2,361	124,618		
2	Food Purchase		77,077		77,077		77,077	(341)	76,736		
3	Housekeeping	84,336	14,523	91	98,950		98,950	19	98,969		
4	Laundry	321	2,810		3,131		3,131		3,131		
5	Heat and Other Utilities			45,931	45,931		45,931	136	46,067		
6	Maintenance	29,465	9,670	20,342	59,477		59,477	936	60,413		
7	Other (specify):* Home Office Ben. Allocation										
8	<b>TOTAL General Services</b>	227,735	110,640	68,448	406,823		406,823	3,111	409,934		
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		
10	Nursing and Medical Records	544,787	45,536	4,442	594,765		594,765	(59)	594,706		
10a	Therapy			159,133	159,133		159,133		159,133		
11	Activities	23,530	114	27	23,671		23,671	(2,390)	21,281		
12	Social Services	21,500			21,500		21,500		21,500		
13	CNA Training										
14	Program Transportation										
15	Other (specify):* Home Office Ben. Allocation										
16	<b>TOTAL Health Care and Programs</b>	589,817	45,650	173,202	808,669		808,669	(2,449)	806,220		
	<b>C. General Administration</b>										
17	Administrative			182,600	182,600		182,600	(119,201)	63,399		
18	Directors Fees										
19	Professional Services			6,091	6,091		6,091	31,122	37,213		
20	Dues, Fees, Subscriptions & Promotions			1,055	1,055		1,055	1,747	2,802		
21	Clerical & General Office Expenses		3,053	6,226	9,279		9,279	26,470	35,749		
22	Employee Benefits & Payroll Taxes			136,336	136,336		136,336	14,376	150,712		
23	Inservice Training & Education							182	182		
24	Travel and Seminar							41	41		
25	Other Admin. Staff Transportation			5,886	5,886		5,886	1,858	7,744		
26	Insurance-Prop.Liab.Malpractice			16,806	16,806		16,806	9,150	25,956		
27	Other (specify):* Home Office Ben. Allocation										
28	<b>TOTAL General Administration</b>		3,053	355,000	358,053		358,053	(34,255)	323,798		
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	817,552	159,343	596,650	1,573,545		1,573,545	(33,593)	1,539,952		

\*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 Rehab & Hlth Care Ctr

#0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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	
	<b>D. Ownership</b>											
30	Depreciation			472	472	472	55,394	55,866				30
31	Amortization of Pre-Op. & Org.						9,615	9,615				31
32	Interest						109,120	109,120				32
33	Real Estate Taxes						19,366	19,366				33
34	Rent-Facility & Grounds			304,965	304,965	304,965	(304,965)					34
35	Rent-Equipment & Vehicles			23,687	23,687	23,687	359	24,046				35
36	Other (specify):* Home Office Ben. Allocation											36
37	<b>TOTAL Ownership</b>			329,124	329,124	329,124	(111,111)	218,013				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,483		42,483	42,483		42,483				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,979	102,979	102,979		102,979				42
43	Other (specify):* Home Office Ben. Allocati		87	166,017	166,104	166,104	(166,104)					43
44	<b>TOTAL Special Cost Centers</b>		42,570	268,996	311,566	311,566	(166,104)	145,462				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	817,552	201,913	1,194,770	2,214,235	2,214,235	(310,808)	1,903,427				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 Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**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	(345)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,950)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	631	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(154,668)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,170)	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	(9,970)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (168,494)</b>		<b>\$</b>	<b>30</b>

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)	(142,314)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (142,314)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (310,808)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

Benton Rehab & Hlth Care Ctr

ID# 0047407

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (3,757)	43	1
2	X-Rays-Part A	(3,542)	43	2
3	To offset Nursing Supplies Revenue	(131)	10	3
4	Offset Transportation Revenue	(2,390)	11	4
5	Disallowed Chamber of Commerce Dues	(150)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>		(9,970)	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%	\$ 0	\$	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		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%	0		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%	119	119	12
13	V							13
14	Total		\$			\$ 119	\$ * 119	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%	\$ 32	\$	32	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	0			16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0			17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0			18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	0			19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0			20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0			21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0			22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	462		462	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	0			24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0			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		\$			\$ 494	\$ *	494	39

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

Facility Name &amp; ID Number

Benton Rehab &amp; Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	19,665	19,665	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,790	1,790	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%	(3,326)	(3,326)	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,228	1,228	33
34	V	31 Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	46	46	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		\$			\$ 19,403	\$ * 19,403	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,361	\$ 2,361
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	19	19
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	136	136
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	936	936
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%	72	72
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	182,600	Petersen Health Care Management, Inc.	100.00%	63,399	(119,201)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	4,176	4,176
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	75	75
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	26,470	26,470
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,702	17,702
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	182	182
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	41	41
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,858	1,858
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	285	285
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%	4,240	4,240
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	137	137
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	309	309
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	359	359
39	Total		\$ 182,600			\$ 122,761	\$ * (59,839)

\* 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	19 Professional Services	\$	Benton Land		\$ 7,162	\$ 7,162
16	V	26 Insurance-Property		Benton Land		3,348	3,348
17	V	26 Insurance-Mortgage		Benton Land		5,517	5,517
18	V	30 Depreciation		Benton Land		48,833	48,833
19	V	31 Amortization		Benton Land		9,615	9,615
20	V	32 Interest		Benton Land		108,942	108,942
21	V	33 Real Estate Taxes		Benton Land		19,057	19,057
22	V	34 Rent-Income and Grounds	304,965	Benton Land			(304,965)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 304,965			\$ 202,474	\$ * (102,491)

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

Facility Name &amp; ID Number

Benton Rehab &amp; Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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 Hospitality L	Peoria	Hospitality	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	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	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 &amp; ID Number

Benton Rehab &amp; Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

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

Facility Name &amp; ID Number

Benton Rehab &amp; Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

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

Facility Name & ID Number

Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	12,183	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	12,183	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	12,183	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	12,183	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	12,183	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	12,183	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	12,183	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	12,183	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	12,183	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	12,183	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	12,183	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	12,183	119	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	12,183	32	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	12,183	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	12,183	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	12,183	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	12,183	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	12,183	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	12,183	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	12,183	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	12,183	462	21
22	32	Interest	Resident Days	1,553,881	75	0	0	12,183	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	12,183	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	12,183	0	24
25	TOTALS					\$ 78,110	\$		\$ 613	25

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	210,530	9	\$	\$	12,183	\$	1
2	2	Food	Resident Days	210,530	9			12,183		2
3	3	Housekeeping	Resident Days	210,530	9			12,183		3
4	4	Laundry	Resident Days	210,530	9			12,183		4
5	5	Utilities	Resident Days	210,530	9			12,183		5
6	6	Maintenance	Resident Days	210,530	9			12,183		6
7	7	Mgmt. Allocation of Benefits	Resident Days	210,530	9			12,183		7
8	10	Nursing and Medical Records	Resident Days	210,530	9			12,183		8
9	15	Mgmt. Allocation of Benefits	Resident Days	210,530	9			12,183		9
10	17	Administrative	Resident Days	210,530	9			12,183		10
11	19	Professional Services	Resident Days	210,530	9	339,821		12,183	19,665	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	210,530	9	30,934		12,183	1,790	12
13	21	Clerical and General Office	Resident Days	210,530	9			12,183		13
14	22	Employee Benefits & Payroll	Resident Days	210,530	9	(57,473)		12,183	(3,326)	14
15	23	Inservice Training & Education	Resident Days	210,530	9			12,183		15
16	24	Travel and Seminar	Resident Days	210,530	9			12,183		16
17	25	Other Admin. Staff Transport.	Resident Days	210,530	9			12,183		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	210,530	9			12,183		18
19	30	Depreciation	Resident Days	210,530	9	21,216		12,183	1,228	19
20	31	Amortization	Resident Days	210,530	9			12,183		20
21	32	Interest	Resident Days	210,530	9	795		12,183	46	21
22	33	Real Estate Taxes	Resident Days	210,530	9			12,183		22
23	34	Rent-Facility and Grounds	Resident Days	210,530	9			12,183		23
24	35	Rent-Equipment & Vehicles	Resident Days	210,530	9			12,183		24
25	TOTALS					\$ 335,293	\$		\$ 19,403	25

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 301,135	\$ 292,840	12,183	\$ 2,361	1
2	2	Food	Resident Days	1,553,881	75	480		12,183	4	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	12,183	19	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		12,183	136	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	12,183	936	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			12,183		6
7	9	Medical Director	Resident Days	1,553,881	75			12,183		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		12,183	72	8
9	10A	Therapy	Resident Days	1,553,881	75			12,183		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			12,183		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	12,183	63,399	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		12,183	4,176	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		12,183	75	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	12,183	26,470	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		12,183	17,702	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		12,183	182	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		12,183	41	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		12,183	1,858	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		12,183	285	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			12,183		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		12,183	4,240	21
22	32	Interest	Resident Days	1,553,881	75	17,439		12,183	137	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		12,183	309	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		12,183	359	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 122,761	25

**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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Capital Finance		X	Mortgage	Varies	1/1/15	\$ 2,927,200	\$ 2,811,171	12/31/24	Varies	\$ 110,003	1				
2												2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 2,927,200	\$ 2,811,171			\$ 110,003	9				
<b>B. Non-Facility Related*</b>																
10											(1,066)	10				
11											46	11				
12											137	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (883)	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 2,927,200	\$ 2,811,171			\$ 109,120	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,517 Line # 26

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>19,092</b>		<b>1</b>
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.)		\$	<b>18,793</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(299)</b>		<b>3</b>
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>19,356</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>309</b>	<b>Home Office Allocation</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>19,366</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>17,232</u>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2011	<u>17,455</u>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$
	2012	<u>18,008</u>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2013	<u>18,530</u>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2014	<u>18,793</u>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Accrual based on prior year tax bill.</b>					

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Benton Rehab & Hlth Care Ctr COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0047407

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

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

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-07-378-005</u>	<u>Long-Term Care Facility</u>	\$ <u>18,576.82</u>	\$ <u>18,576.82</u>
2. <u>08-07-382-005</u>	<u>Long-Term Care Facility</u>	\$ <u>216.22</u>	\$ <u>216.22</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>18,793.04</u></u>	\$ <u><u>18,793.04</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.

**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: 197,297 2. Number of Years Over Which it is Being Amortized: 20  
 3. Current Period Amortization: 9,615 4. Dates Incurred: 2012-2013 Loan Costs

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>122,404</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>122,404</b>		<b>\$ 54,000</b>	<b>3</b>

**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	73	2005	1968	\$ 959,500	\$	25	\$ 38,379	\$ 38,379	\$ 402,982	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements	2005		15,000		15	1,000	1,000	10,500	9
10	Smoke Alarms	2007		2,341		10	234	234	1,989	10
11	Interior Signage	2007		3,678		10	368	368	3,128	11
12	Canopy	2007		3,572		10	357	357	3,035	12
13	Air Compressor Repair	2009		2,958		7	423	423	2,749	13
14	Sprinkler System Replacement	2010		56,828		15	3,788	3,788	20,834	14
15	Generator	2011		16,755		15	1,117	1,117	7,825	15
16	Windows	2013		18,111		25	724	724	1,810	16
17	Gutter Repair	2014		3,043		7	435	435	653	17
18	Concrete Repair	2014		3,000		15	200	200	300	18
19	Soffit, Facia, and Downspout Replacement	2014		10,454		15	697	697	1,046	19
20	Water Heater	2015		2,986		7	214	214	214	20
21	Air Conditioner	2015		3,595		15	120	120	120	21
22	Roof Repair	2015		1,467		7	105	105	105	22
23										23
24										24
25										25
26										26
27										27
28										28
29	Land Improvements Booked				1,000			(1,000)		29
30	Building Booked				38,405			(38,405)		30
31	Building Improvement Booked				8,223			(8,223)		31
32										32
33	2015-Home Office Allocation-Building Improvements			5,331			128	128		33
34	2015-Home Office Allocation-Land Improvements			498			32	32		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

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									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,109,117	\$ 47,628		\$ 48,321	\$ 693	\$ 457,290	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	\$ 15,943	\$ 1,677	\$ 1,594	\$ (83)	5-10 yrs.	\$ 9,245	71
72	Current Year Purchases	3,610		181	181	10 yrs.	181	72
73	Fully Depreciated Assets	190,227					190,227	73
74	Home Office Allocation			5,770	5,770			74
75	TOTALS	\$ 209,780	\$ 1,677	\$ 7,545	\$ 5,868		\$ 199,653	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)	\$ 1,372,897	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,305	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,866	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,561	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 656,943	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 Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \$ 24,046 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	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**Benton Rehab & Hlth Care Ctr  
0047407**

**Period Beginning** 1/1/2015  
**Period End** 12/31/2015

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 14,988
Dishwasher	712
Copier	7,987
Home Office Allocation	<u>359</u>
	<u><u>24,046</u></u>

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2015 Ending: 12/31/2015  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	\$	3,944	\$ 59,154	\$	3,944	\$ 59,154	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,197	17,957		1,197	17,957	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,468	82,022		5,468	82,022	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				42,483		42,483	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	<b>TOTAL</b>			\$	10,609	\$ 159,133	\$ 42,483	10,609	\$ 201,616	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 Rehab & Hlth Care Ctr**

# **0047407**

Report Period Beginning: **1/1/2015**

Ending: **12/31/2015**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2015** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (973,392)	\$ (973,392)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,202</u> )	835,965	835,965	3
4	Supply Inventory (priced at <u>Cost</u> )	6,305	6,305	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,477	36,769	6
7	Other Prepaid Expenses		25,305	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	2,434	2,434	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (107,211)	\$ (66,614)	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		54,000	13
14	Buildings, at Historical Cost		964,831	14
15	Leasehold Improvements, at Historical Cost		144,286	15
16	Equipment, at Historical Cost	6,824	209,780	16
17	Accumulated Depreciation (book methods)	(665)	(656,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		192,297	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(12,019)	20
21	Restricted Funds		397,208	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,159	\$ 1,293,440	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (101,052)	\$ 1,226,826	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 381,656	\$ 410,571	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,721	41,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,561	48,561	31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,356	32
33	Accrued Interest Payable		9,019	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	107,782	107,782	36
37	<u>Accrued Management Fees</u>	35,680	35,680	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 615,400	\$ 672,690	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,811,171	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Intercompany Loans</u>	1,707,656	45,255	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,707,656	\$ 2,856,426	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,323,056	\$ 3,529,116	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,424,108)	\$ (2,302,290)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (101,052)	\$ 1,226,826	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,251,356)	1
2	Restatements (describe):		2
3	Prior Period Adjustment Made After Cost Report Was Filed	2,428	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,248,928)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(175,180)	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)	\$ (175,180)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (2,424,108)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,748,148	1
2	Discounts and Allowances for all Levels	(75,673)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,672,475</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	285,526	6
7	Oxygen	158	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 285,684</b>	8
<b>C. Other Operating Revenue</b>			
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	345	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,959	20
21	Other Medical Services	3,598	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 78,370</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 5</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	2,390	28
28a	<u>Miscellaneous Revenue</u>	131	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,521</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,039,055</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	406,823	31
32	Health Care	808,669	32
33	General Administration	358,053	33
<b>B. Capital Expense</b>			
34	Ownership	329,124	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	208,587	35
36	Provider Participation Fee	102,979	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,214,235</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(175,180)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (175,180)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,109,729	44
45	Private Pay - Net Inpatient Revenue	226,219	45
46	Medicare - Net Inpatient Revenue	313,284	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	24,821	47
48	Other-(specify) <u>Charity Therapy Allowance</u>	(1,578)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,672,475</b>	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 Benton Rehab & Hlth Care Ctr

# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**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	1,923	2,019	\$ 53,983	\$ 26.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,814	2,978	59,857	20.10	3
4	Licensed Practical Nurses	8,589	9,041	164,365	18.18	4
5	CNAs & Orderlies	22,329	23,323	223,530	9.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,099	1,107	11,162	10.08	9
10	Activity Assistants	897	937	12,368	13.20	10
11	Social Service Workers	1,704	1,722	21,500	12.49	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,703	14.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,527	9,020	82,910	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,101	29,465	14.02	17
18	Housekeepers	8,692	9,238	84,336	9.13	18
19	Laundry	38	38	321	8.45	19
20	Administrator	2,041	2,137	63,399	29.67	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	2,050	2,050	43,052	21.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	64,768	67,791	\$ 880,951 *	\$ 13.00	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	40	\$ 2,084	L1, C3	35
36	Medical Director	Monthly	9,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,620	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	347	L10A, 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)	48	\$ 14,651		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

**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	
Ron Slaviero	Administrator	0	\$ 30,211	Workers' Compensation Insurance	\$ 43,062	IDPH License Fee	\$	
LaWanna Kiefer	Administrator	0	30,226	Unemployment Compensation Insurance	25,542	Advertising: Employee Recruitment		
Tracy Garrett	Administrator	0	2,962	FICA Taxes	61,458	Health Care Worker Background Check		
				Employee Health Insurance	5,685	(Indicate # of checks performed <u>57</u> )	761	
				Employee Meals		Miscellaneous Licenses & Permits		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	294	
				Employee Relations	400	Home Office Allocation	1,897	
				Employee Retirement	189			
				Home Office Allocation	14,376			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 63,399					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense	(150)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 182,600			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 182,600		\$ 150,712	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 4,421			\$	Out-of-State Travel	\$
Frontier	Computer Services		732					
Honkamp Krueger & Co.	Accounting Fees		938				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	41
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 6,091			\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 41

\* Attach copy of IMRF notifications

\*\*See instructions.

Benton Rehab & Hlth Care Ctr  
0047407

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,091

Home Office Allocation

Denton's US LLP	Legal	59
Applegate and Thorne	Legal	9
Miller Hall and Triggs	Legal	9
Healthcare Resources International	Legal	49
Lexis Nexis	Legal	3
GoffWilson	Legal	406
Illinois Secretary of State	Legal	14
Edgerton and Edgerton	Legal	64
Black, Hedin, Ballard, McDonald	Legal	54
Cole Schotz LLC	Legal	143
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	634
Ginoli & Co.	Accountants	7,345
Miscellaneous	Computer Services	30
CCH	Computer Services	7
PTC Select	Computer Services	10
Advanced Answers on Demand	Computer Services	1300
Stratus Networks	Computer Services	236
Kemper Technology	Computer Services	348
AT&T	Computer Services	3
Ability Network	Computer Services	335
CIAN	Computer Services	236
Comcast	Computer Services	9
Emdeon	Computer Services	19
Charter Communications	Computer Services	16

Allscripts	Computer Services	12
Allpayer Exchange	Computer Services	8
E-Health Technologies	Computer Services	5
Macquarie Technology Services	Computer Services	8
Optimizer	Other Prof Fees	23
D.J. Howard Appraisers	Other Prof Fees	21
Key Corporate Services	Other Prof Fees	69
Consolidated Land Surveying	Other Prof Fees	43
Alan Litwiller	Other Prof Fees	9
Registered Agent Solutions	Other Prof Fees	13
Duane Morris LLP	Other Prof Fees	3641
Marotta Gund Budd & Derza	Other Prof Fees	15682

Total (agree to Schedule V, line 19, column 8)	<u><u>37,213</u></u>
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**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												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Benton Rehab & Hlth Care Ctr# 0047407

Report Period Beginning:

1/1/2015

Ending:

12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,521 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 102,979  
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. \$ 345
- (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. \$ 2,390
- 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? 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.