

Facility Name & ID Number Rock River Gardens

0053322 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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	
8	SNF				8
9	SNF/PED				9
10	ICF	21,334	922		22,256
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	21,334	922		22,256

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.11%

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 11/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/2014 NO

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

Medicare Intermediary N/A

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
	A. General Services										
1	Dietary	134,322	10,797	1,543	146,662		146,662	4,313	150,975		1
2	Food Purchase		131,663		131,663		131,663	(3,552)	128,111		2
3	Housekeeping	86,664	15,934		102,598		102,598	34	102,632		3
4	Laundry	19,055	2,020		21,075		21,075		21,075		4
5	Heat and Other Utilities			44,353	44,353		44,353	248	44,601		5
6	Maintenance	54,600	4,825	26,196	85,621		85,621	1,711	87,332		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	294,641	165,239	72,092	531,972		531,972	2,754	534,726		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	687,172	21,574	5,097	713,843		713,843	132	713,975		10
10a	Therapy										10a
11	Activities	54,932	52		54,984		54,984		54,984		11
12	Social Services	84,701	23		84,724		84,724		84,724		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	826,805	21,649	29,097	877,551		877,551	132	877,683		16
	C. General Administration										
17	Administrative			158,600	158,600		158,600	(86,600)	72,000		17
18	Directors Fees										18
19	Professional Services			1,177	1,177		1,177	16,728	17,905		19
20	Dues, Fees, Subscriptions & Promotions			3,633	3,633		3,633	563	4,196		20
21	Clerical & General Office Expenses	30,078	4,305	10,009	44,392		44,392	48,338	92,730		21
22	Employee Benefits & Payroll Taxes			135,487	135,487		135,487	32,338	167,825		22
23	Inservice Training & Education			59	59		59	333	392		23
24	Travel and Seminar							76	76		24
25	Other Admin. Staff Transportation			6,693	6,693		6,693	3,394	10,087		25
26	Insurance-Prop.Liab.Malpractice			19,342	19,342		19,342	521	19,863		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	30,078	4,305	335,000	369,383		369,383	15,691	385,074		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,151,524	191,193	436,189	1,778,906		1,778,906	18,577	1,797,483		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			475	475		475	10,694	11,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							12	12			32
33	Real Estate Taxes			6,835	6,835		6,835	565	7,400			33
34	Rent-Facility & Grounds			51,520	51,520							34
35	Rent-Equipment & Vehicles			2,987	2,987		2,987	655	3,642			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			61,817	61,817		10,297	11,926	22,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131		131		131		131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,377	173,377		173,377		173,377			42
43	Other (specify):* Home Office Ben. Allocati		26	18,824	18,850		18,850	(18,850)				43
44	TOTAL Special Cost Centers		157	192,201	192,358		192,358	(18,850)	173,508			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,151,524	191,350	690,207	2,033,081		1,981,561	11,653	1,993,214			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 Rock River Gardens

0053322

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	(3,559)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,667)	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				9
10	Interest and Other Investment Income	(238)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	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	(10,131)	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	(1,171)	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	(788)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,665)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	34,318	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,318		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 11,653		37

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

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

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

Rock River Gardens

ID# 0053322

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Office Supplies Revenue	\$ (18)	21	1
2	Disallowed Special Events	(770)	43	2
3				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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(788)	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%	217	217	12	
13	V							13	
14	Total		\$			\$ 217	\$ *	217	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%	\$ 58	\$	58	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%	843		843	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		\$			\$ 901	\$ *	901	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	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Midwest Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	8,882	8,882	25	
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	368	368	26	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	2,105	2,105	34	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 11,355	\$ *	11,355	39

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

Facility Name & ID Number

Rock River Gardens

0053322

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 Care Management, Inc.	100.00%	\$ 4,313	\$	4,313	15
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	7		7	16
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	34		34	17
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	248		248	18
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,711		1,711	19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			20
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0			21
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	132		132	22
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			24
25	V	17 Administrative	158,600	Petersen Health Care Management, Inc.	100.00%	72,000		(86,600)	25
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	7,629		7,629	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	137		137	27
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	48,356		48,356	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	32,338		32,338	29
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	333		333	30
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	76		76	31
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,394		3,394	32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	521		521	33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0			34
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	7,746		7,746	35
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	250		250	36
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	565		565	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	655		655	38
39	Total		\$ 158,600			\$ 180,445	\$ *	21,845	39

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

Facility Name & ID Number

Rock River Gardens

0053322

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 & ID Number

Rock River Gardens

0053322

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 & ID Number

Rock River Gardens

0053322

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

Rock River Gardens

0053322

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 Rock River Gardens # 0053322 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 Rock River Gardens

0053322

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	22,256	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	22,256	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	22,256	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	22,256	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	22,256	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	22,256	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	22,256	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	22,256	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	22,256	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	22,256	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	22,256	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	22,256	217	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	22,256	58	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	22,256	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	22,256	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	22,256	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	22,256	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	22,256	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	22,256	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	22,256	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	22,256	843	21
22	32	Interest	Resident Days	1,553,881	75	0	0	22,256	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	22,256	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	22,256	0	24
25	TOTALS					\$ 78,110	\$		\$ 1,118	25

Facility Name & ID Number Rock River Gardens

0053322

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 Midwest 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	160,585	10		22,256		1
2	2	Food	Resident Days	160,585	10		22,256		2
3	3	Housekeeping	Resident Days	160,585	10		22,256		3
4	4	Laundry	Resident Days	160,585	10		22,256		4
5	5	Utilities	Resident Days	160,585	10		22,256		5
6	6	Maintenance	Resident Days	160,585	10		22,256		6
7	7	Mgmt. Allocation of Benefits	Resident Days	160,585	10		22,256		7
8	10	Nursing and Medical Records	Resident Days	160,585	10		22,256		8
9	15	Mgmt. Allocation of Benefits	Resident Days	160,585	10		22,256		9
10	17	Administrative	Resident Days	160,585	10		22,256		10
11	19	Professional Services	Resident Days	160,585	10	64,091	22,256	8,882	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	160,585	10	2,658	22,256	368	12
13	21	Clerical and General Office	Resident Days	160,585	10		22,256		13
14	22	Employee Benefits & Payroll	Resident Days	160,585	10		22,256		14
15	23	Inservice Training & Education	Resident Days	160,585	10		22,256		15
16	24	Travel and Seminar	Resident Days	160,585	10		22,256		16
17	25	Other Admin. Staff Transport.	Resident Days	160,585	10		22,256		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	160,585	10		22,256		18
19	27	Mgmt. Allocation of Benefits	Resident Days	160,585	10		22,256		19
20	30	Depreciation	Resident Days	160,585	10	15,190	22,256	2,105	20
21	32	Interest	Resident Days	160,585	10		22,256		21
22	33	Real Estate Taxes	Resident Days	160,585	10		22,256		22
23	34	Rent-Facility and Grounds	Resident Days	160,585	10		22,256		23
24	35	Rent-Equipment & Vehicles	Resident Days	160,585	10		22,256		24
25	TOTALS					\$ 81,939	\$	\$ 11,355	25

Facility Name & ID Number Rock River Gardens

0053322

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	22,256	\$ 4,313	1
2	2	Food	Resident Days	1,553,881	75	480		22,256	7	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	22,256	34	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		22,256	248	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	22,256	1,711	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			22,256		6
7	9	Medical Director	Resident Days	1,553,881	75			22,256		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		22,256	132	8
9	10A	Therapy	Resident Days	1,553,881	75			22,256		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			22,256		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	22,256	72,000	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		22,256	7,629	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		22,256	137	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	22,256	48,356	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		22,256	32,338	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		22,256	333	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		22,256	76	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		22,256	3,394	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		22,256	521	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			22,256		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		22,256	7,746	21
22	32	Interest	Resident Days	1,553,881	75	17,439		22,256	250	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		22,256	565	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		22,256	655	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 180,445	25

Facility Name & ID Number

Rock River Gardens

0053322

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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		8	9	10									
					Name of Lender	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						\$	\$			\$	1							
2	N/A										2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	12							
15	TOTALS (line 9+line14)					\$	\$			\$	12							

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2014 report.		\$ 8,389	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.)		\$ 10,073	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,684	3																													
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 5,151	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	565	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 7,400	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>10,073</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	10,073	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2010	_____	8																														
2011	_____	9																														
2012	_____	10																														
2013	_____	11																														
2014	10,073	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														
Accrual based on prior year tax bill.																																

NOTES:

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

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.**

Facility Name & ID Number Rock River Gardens

0053322 Report Period Beginning:

1/1/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Land</u>	<u>217,800</u>		\$	1
2					2
3	TOTALS	217,800		\$	3

Facility Name & ID Number **Rock River Gardens**

0053322

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Water Heater		2015		6,645		7	475	475	475
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	Building Improvement Booked					475			(475)	
31										31
32	2015-Home Office Allocation-Building Improvements				9,738			234	234	
33	2015-Home Office Allocation-Land Improvements				909			58	58	
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Rock River Gardens**

0053322

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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)		\$ 17,292	\$ 475		\$ 767	\$ 292	\$ 475	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,402	10,402			74
75	TOTALS	\$	\$	\$ 10,402	\$ 10,402		\$	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)	\$ 17,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 475	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,169	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,694	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 475	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: H & I Properties

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:	<u>1958</u>	<u>70</u>	<u>9/1/2015</u>	\$ <u>51,220</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		70		\$ 51,220			7

10. Effective dates of current rental agreement:

Beginning 9/1/2015

Ending 8/31/2020

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

Fiscal Year Ending Annual Rent

12. /2016 \$ 154,560

13. /2017 \$ 154,560

14. /2018 \$ 154,560

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: \$ 3,642 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	TOTAL		\$	\$	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.

Rock River Gardens

0053322

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	\$ -
Dishwasher	58
Copier	2,929
Home Office Allocation	655
	<u>3,642</u>

Facility Name & ID Number Rock River Gardens # 0053322 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		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		hrs	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													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							131					131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$		\$		\$		131		\$		131		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 **Rock River Gardens**

0053322

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 450,288	\$ 450,288	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	177,392	177,392	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,233	22,233	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposits</u>	6,737	6,737	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 656,650	\$ 656,650	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		9,738	14
15	Leasehold Improvements, at Historical Cost	6,645	7,554	15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(475)	(475)	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)	\$ 6,170	\$ 16,817	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 662,820	\$ 673,467	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 173,076	\$ 173,076	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,361	38,361	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,146	38,146	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,151	5,151	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	121,264	121,264	36
37	<u>Accrued Management Fees</u>	166,298	166,298	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 542,296	\$ 542,296	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P-Prior Owner</u>	1,551	1,551	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,551	\$ 1,551	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 543,847	\$ 543,847	46
47	TOTAL EQUITY(page 18, line 24)	\$ 118,973	\$ 129,620	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 662,820	\$ 673,467	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 83,597	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 83,597	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 35,376	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)	\$ 35,376	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)	\$ 118,973	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,064,642	1
2	Discounts and Allowances for all Levels	(2,309)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,062,333	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,309	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,309	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	3,559	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,559	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	238	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 238	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue		28
28a	Miscellaneous Revenue	18	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,068,457	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	531,972	31
32	Health Care	877,551	32
33	General Administration	369,383	33
B. Capital Expense			
34	Ownership	61,817	34
C. Ancillary Expense			
35	Special Cost Centers	18,981	35
36	Provider Participation Fee	173,377	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,033,081	40
41	Income before Income Taxes (line 30 minus line 40)**	35,376	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,376	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,973,390	44
45	Private Pay - Net Inpatient Revenue	91,252	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(2,309)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,062,333	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 Rock River Gardens

0053322

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	2,080	2,080	\$ 65,260	\$ 31.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,571	4,589	123,065	26.82	3
4	Licensed Practical Nurses	6,961	7,008	140,654	20.07	4
5	CNAs & Orderlies	29,619	29,930	339,012	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	1,899	24,588	12.95	9
10	Activity Assistants	3,416	3,424	30,344	8.86	10
11	Social Service Workers	7,310	7,332	84,701	11.55	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,134	12.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,048	12,122	109,188	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,963	4,021	54,600	13.58	17
18	Housekeepers	9,131	9,354	86,664	9.26	18
19	Laundry	1,980	2,004	19,055	9.51	19
20	Administrator	2,080	2,080	72,000	34.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,034	2,138	30,078	14.07	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	1,785	2,023	19,181	9.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,957	92,084	\$ 1,223,524 *	\$ 13.29	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	31	\$ 1,543	L1, C3	35
36	Medical Director	Monthly	24,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,097	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	31	\$ 30,640		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

Facility Name & ID Number **Rock River Gardens**

0053322

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

Ending: **12/31/2015**

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		
Angela Mehlbrech	Administrator	0	\$ 72,000	Workers' Compensation Insurance	\$ 12,451	IDPH License Fee	\$ 1,625		
				Unemployment Compensation Insurance	37,327	Advertising: Employee Recruitment	582		
				FICA Taxes	87,573	Health Care Worker Background Check			
				Employee Health Insurance	(2,470)	(Indicate # of checks performed <u>52</u>)	1,032		
				Employee Meals		Miscellaneous Licenses & Permits	359		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	35		
				Employee Relations	606	Home Office Allocation	563		
				Home Office Allocation	32,338				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,196			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 158,600				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 158,600	TOTAL (agree to Schedule V, line 22, col.8)			\$ 167,825		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
T6 Broadband	Computer Services		\$ 318				Out-of-State Travel	\$	
Comcast Cable	Computer Services		859						
				N/A			In-State Travel		
							Seminar Expense		
							Home Office Allocation	76	
							Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,177	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 76

* Attach copy of IMRF notifications

**See instructions.

Rock River Gardens

0053322

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)		1,177
Home Office Allocation		
Denton's US LLP	Legal	108
Applegate and Thorne	Legal	17
Miller Hall and Triggs	Legal	16
Healthcare Resources International	Legal	89
Lexis Nexis	Legal	6
GoffWilson	Legal	742
CliftonLarson Allen	Accountants	1,158
Ginoli & Co.	Accountants	2,786
Miscellaneous	Computer Services	53
CCH	Computer Services	13
PTC Select	Computer Services	18
Advanced Answers on Demand	Computer Services	2375
Stratus Networks	Computer Services	432
Kemper Technology	Computer Services	635
AT&T	Computer Services	6
Ability Network	Computer Services	612
CIAN	Computer Services	430
Comcast	Computer Services	16
Emdeon	Computer Services	36
Charter Communications	Computer Services	29
Allscripts	Computer Services	21
Allpayer Exchange	Computer Services	14
E-Health Technologies	Computer Services	9
Macquarie Technology Services	Computer Services	15
Optimizer	Other Prof Fees	42

D.J. Howard Appraisers	Other Prof Fees	38
Key Corporate Services	Other Prof Fees	126
Consolidated Land Surveying	Other Prof Fees	79
Alan Litwiller	Other Prof Fees	16
Marotta Gund Budd Derza	Other Prof Fees	6791

Total (agree to Schedule V, line 19, column 8) 17,905

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

