



Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,476	2,476		18,952	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,476	2,476		18,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.13%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?  
 Date started 10/1/05

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 10/1/05 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS  
 ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name &amp; ID Number Benton Rehabilitation &amp; Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	93,614	9,101		102,715		102,715	1,883	104,598		1
2	Food Purchase		79,323		79,323		79,323	(3,447)	75,876		2
3	Housekeeping	73,896	8,584		82,480		82,480	61	82,541		3
4	Laundry	15,574	8,493		24,067		24,067		24,067		4
5	Heat and Other Utilities			45,186	45,186		45,186	250	45,436		5
6	Maintenance	27,798	23,250	3,057	54,105		54,105	4,668	58,773		6
7	Other (specify):* Home Ofc. Benefit							1,173	1,173		7
8	<b>TOTAL General Services</b>	210,882	128,751	48,243	387,876		387,876	4,588	392,464		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	430,348	32,502	972	463,822		463,822	5,816	469,638		10
10a	Therapy			26,739	26,739		26,739	447	27,186		10a
11	Activities		787	2,851	3,638		3,638		3,638		11
12	Social Services	43,735			43,735		43,735		43,735		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefit							1,830	1,830		15
16	<b>TOTAL Health Care and Programs</b>	474,083	33,289	40,162	547,534		547,534	8,093	555,627		16
	<b>C. General Administration</b>										
17	Administrative	57,760		33,500	91,260		91,260	(19,093)	72,167		17
18	Directors Fees										18
19	Professional Services			1,989	1,989		1,989	7,832	9,821		19
20	Dues, Fees, Subscriptions & Promotions			9,346	9,346		9,346	928	10,274		20
21	Clerical & General Office Expenses		2,883	7,264	10,147		10,147	26,653	36,800		21
22	Employee Benefits & Payroll Taxes			119,323	119,323		119,323	3,517	122,840		22
23	Inservice Training & Education							173	173		23
24	Travel and Seminar							500	500		24
25	Other Admin. Staff Transportation			1,837	1,837		1,837	2,044	3,881		25
26	Insurance-Prop.Liab.Malpractice			16,364	16,364		16,364	1,068	17,432		26
27	Other (specify):* Home Ofc. Benefit							5,214	5,214		27
28	<b>TOTAL General Administration</b>	57,760	2,883	189,623	250,266		250,266	28,836	279,102		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	742,725	164,923	278,028	1,185,676		1,185,676	41,517	1,227,193		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\*See schedule of adjustments attached at end of cost report.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			67,695	67,695		67,695	6,117	73,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,451	116,451		116,451	16,270	132,721			32
33	Real Estate Taxes			15,600	15,600		15,600	1,872	17,472			33
34	Rent-Facility & Grounds							853	853			34
35	Rent-Equipment & Vehicles			44,526	44,526		44,526	557	45,083			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			244,272	244,272		244,272	25,669	269,941			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			42,051	42,051		42,051		42,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):* <b>Nonallowable Cost</b>			7,356	7,356		7,356	(7,356)				43
44	<b>TOTAL Special Cost Centers</b>			89,375	89,375		89,375	(7,356)	82,019			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	742,725	164,923	611,675	1,519,323		1,519,323	59,830	1,579,153			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,278)	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	(195)	30		9
10	Interest and Other Investment Income	(3,194)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(180)	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				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	(1,442)	43		24
25	Fund Raising, Advertising and Promotional	(84)	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 <u>See Pg 5A</u>	(10,183)	var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (16,556)		\$	30

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)	76,386	var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 76,386		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 59,830		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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Benton Rehabilitation & Health Care Center

ID# 0047407

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (137)	43	1
2	Labs - Part A	53	43	2
3	Special events	(4,288)	43	3
4	Offset misc revenue	(205)	21	4
5	Nonallowable architect fees	(421)	19	5
6	Nonallowable Travel Expense	(5,185)	24	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>	(10,183)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Benton Rehabilitation &amp; Health Care Center

# 0047407

Report Period Beginning:

01/01/06

Ending:

12/31/06

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	1,348	0	535	0	0	0	0	0	0	0	1,883	1
2	Food Purchase	0	66	0	4	0	0	0	0	0	0	0	70	2
3	Housekeeping	0	60	0	1	0	0	0	0	0	0	0	61	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	250	0	0	0	0	0	0	0	0	0	250	5
6	Maintenance	0	3,427	0	1,241	0	0	0	0	0	0	0	4,668	6
7	Other (specify):*	0	540	0	633	0	0	0	0	0	0	0	1,173	7
8	<b>TOTAL General Services</b>	0	5,691	0	2,414	0	0	0	0	0	0	0	8,105	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,872	0	944	0	0	0	0	0	0	0	5,816	10
10a	Therapy	0	447	0	0	0	0	0	0	0	0	0	447	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,506	0	324	0	0	0	0	0	0	0	1,830	15
16	<b>TOTAL Health Care and Programs</b>	0	6,825	0	1,268	0	0	0	0	0	0	0	8,093	16
	<b>C. General Administration</b>													
17	Administrative	0	(20,218)	0	1,125	0	0	0	0	0	0	0	(19,093)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(421)	5,817	0	2,436	0	0	0	0	0	0	0	7,832	19
20	Fees, Subscriptions & Promotions	0	570	0	358	0	0	0	0	0	0	0	928	20
21	Clerical & General Office Expenses	(205)	0	21,412	5,446	0	0	0	0	0	0	0	26,653	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	173	0	0	0	0	0	0	0	0	173	23
24	Travel and Seminar	(5,185)	0	5,185	500	0	0	0	0	0	0	0	500	24
25	Other Admin. Staff Transportation	0	0	1,379	665	0	0	0	0	0	0	0	2,044	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,020	48	0	0	0	0	0	0	0	1,068	26
27	Other (specify):*	0	0	3,784	1,430	0	0	0	0	0	0	0	5,214	27
28	<b>TOTAL General Administration</b>	(5,811)	(13,831)	32,953	12,008	0	0	0	0	0	0	0	25,319	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(5,811)	(1,315)	32,953	15,690	0	0	0	0	0	0	0	41,517	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Benton Rehabilitation & Health Care Center# 0047407

Report Period Beginning:

01/01/06

Ending:

12/31/06

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(195)	0	5,279	1,033	0	0	0	0	0	0	0	6,117	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,194)	0	2,932	16,532	0	0	0	0	0	0	0	16,270	32
33	Real Estate Taxes	0	0	619	1,253	0	0	0	0	0	0	0	1,872	33
34	Rent-Facility & Grounds	0	0	600	253	0	0	0	0	0	0	0	853	34
35	Rent-Equipment & Vehicles	0	0	314	243	0	0	0	0	0	0	0	557	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,389)</b>	<b>0</b>	<b>9,744</b>	<b>19,314</b>	<b>0</b>	<b>25,669</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,356)	0	0	0	0	0	0	0	0	0	0	(7,356)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(7,356)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,356)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(16,556)</b>	<b>(1,315)</b>	<b>42,697</b>	<b>35,004</b>	<b>0</b>	<b>59,830</b>	<b>45</b>						

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,348	\$ 1,348	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	66	66	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	60	60	3
4	V	4						4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	250	250	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,427	3,427	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	540	540	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,872	4,872	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	447	447	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,506	1,506	10
11	V	17 Administrative	33,500	Petersen Health Care, Inc.	100.00%	13,282	(20,218)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,817	5,817	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	570	570	13
14	Total		\$ 33,500			\$ 32,185	\$ * (1,315)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 21,412	\$ 21,412	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	173	173	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,185	5,185	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,379	1,379	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,020	1,020	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,784	3,784	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,279	5,279	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,932	2,932	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	619	619	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	600	600	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	314	314	25
26	V							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		\$			\$ 42,697	\$ * 42,697	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center# 0047407Report Period Beginning: 01/01/06Ending: 12/31/06

## 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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, Inc.	100.00%	\$ 535	\$ 535	15
16	V	2	Food		Petersen Health Care, Inc.	100.00%	4	4	16
17	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	1	1	17
18	V	4							18
19	V	5							19
20	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,241	1,241	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	633	633	21
22	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	944	944	22
23	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	324	324	24
25	V	17	Administrative		Petersen Health Care, Inc.	100.00%	1,125	1,125	25
26	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,436	2,436	26
27	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	358	358	27
28	V	21	Clerical & General Office		Petersen Health Care, Inc.	100.00%	5,446	5,446	28
29	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	500	500	30
31	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	665	665	31
32	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	48	48	32
33	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,430	1,430	33
34	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,033	1,033	34
35	V	32	Interest		Petersen Health Care, Inc.	100.00%	16,532	16,532	35
36	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,253	1,253	36
37	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	253	253	37
38	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	243	243	38
39	Total			\$			\$ 35,004	\$ * 35,004	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								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	<b>Total</b>			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.83	1.66	Salary	\$ 13,282	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,282		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 West 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	Patient Days	1,141,463	56	\$ 81,179	\$ 18,952	\$ 1,348	1	
2	2	Food	Patient Days	1,141,463	56	3,989	18,952	66	2	
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	18,952	60	3	
4	4								4	
5	5	Utilities	Patient Days	1,141,463	56	15,054	18,952	250	5	
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	18,952	3,427	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	18,952	540	7	
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	18,952	4,872	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	18,952	447	9	
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	18,952	1,506	10	
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	18,952	13,282	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	18,952	5,817	12	
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	18,952	570	13	
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	18,952	21,412	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	18,952	173	15	
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	18,952	5,185	16	
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	18,952	1,379	17	
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	18,952	1,020	18	
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	18,952	3,784	19	
20	30	Depreciation	Patient Days	1,141,463	56	317,964	18,952	5,279	20	
21	32	Interest	Patient Days	1,141,463	56	176,614	18,952	2,932	21	
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	18,952	619	22	
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	18,952	600	23	
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	18,952	314	24	
25	TOTALS					\$ 4,510,235	\$ 2,234,999	\$ 74,882	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 West 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	Patient Days	427,669	46	\$ 12,081	\$ 18,952	\$ 535	1
2	2	Food	Patient Days	427,669	46	93	18,952	4	2
3	3	Housekeeping	Patient Days	427,669	46	28	18,952	1	3
4	4								4
5	5								5
6	6	Maintenance	Patient Days	427,669	46	28,012	18,952	1,241	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282	18,952	633	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	18,952	944	8
9	10A								9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301	18,952	324	10
11	17	Administrative	Patient Days	427,669	46	25,391	18,952	1,125	11
12	19	Professional Services	Patient Days	427,669	46	54,971	18,952	2,436	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088	18,952	358	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	18,952	5,446	14
15	23								15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280	18,952	500	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003	18,952	665	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087	18,952	48	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265	18,952	1,430	19
20	30	Depreciation	Patient Days	427,669	46	23,301	18,952	1,033	20
21	32	Interest	Patient Days	427,669	46	373,049	18,952	16,532	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282	18,952	1,253	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700	18,952	253	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479	18,952	243	24
25	TOTALS					\$ 789,885	\$ 150,702	\$ 35,004	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 1,020,000	\$ 1,005,111	09/20/10	Varies	\$ 87,517	1
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	190,000	189,652	09/20/10	0.1000	28,934	2
3												3
4							Offset Interest Income				(3,194)	4
5							Allocated from Home Office				19,464	5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 1,210,000	\$ 1,194,763			\$ 132,721	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,210,000	\$ 1,194,763			\$ 132,721	15

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>15,545</b>	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.)	2005	\$	<b>15,545</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>15,600</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>1,872</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>17,472</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	<b>15,545</b>	12	
<b>Accrual based on prior year tax bill.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Benton Rehabilitation & Health Care Cente 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 Cos**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-07-378-005</u>	<u>Nursing Home</u>	\$ <u>15,366.68</u>	\$ <u>15,366.68</u>
2. <u>08-07-382-005</u>	<u>Nursing Home</u>	\$ <u>178.30</u>	\$ <u>178.30</u>
3. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,872.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>15,544.98</u>	\$ <u>17,416.98</u>

**B. Real Estate Tax Cost Allocation:**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

**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 Benton Rehabilitation & Health Care Center

# 0047407 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,200 B. General Construction Type: Exterior BRICK & BLOCK Frame MASONARY 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71		2005	1968	\$ 959,500	\$	25	\$ 38,379	\$ 38,379	\$ 57,571	4
5											5
6	Allocated from Home Office			2006	11,303			495	495	495	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	1,500	9
10	Land Improvement Booked					1,000			(1,000)		10
11	Building Booked					38,405			(38,405)		11
12	Building Improvement Booked										12
13											13
14											14
15											15
16											16
17											17
18	Allocated from home office -Land and Improvements			2006	653			61	61	61	18
19	Allocated from home office-Leasehold Improvements			2006	18			1	1	1	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 986,474	\$ 39,405		\$ 39,936	\$ 531	\$ 59,628	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 187,500	\$ 28,290	\$ 27,929	\$ (361)	5	\$ 41,893	71
72	Current Year Purchases	2,727		192	192	5	192	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,755	5,755			74
75	TOTALS	\$ 190,227	\$ 28,290	\$ 33,876	\$ 5,586		\$ 42,085	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77		N/A								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)	\$ 1,230,701	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,812	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,117	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 101,713	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	N/A				87
88					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: 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	Home Office Allocation				853			6
7	TOTAL				\$ 853			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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 45,083 Description: COPIER \$2841, DISHWASHER \$708, MAINT. EQUIP \$71, NURSING \$40906, HOME OFC. \$557  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* 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.

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><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	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)	
<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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	89	\$ 7,110	\$	89	\$ 7,110	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		13	1,121		13	1,121	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		240	18,508	447	240	18,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)			527	42,051		527	42,051	12
13	Other (specify):									13
14	TOTAL			\$	869	\$ 68,790	\$ 447	869	\$ 69,237	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center# 0047407Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(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	\$ 61,334	\$ 61,334	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	408,337	408,337	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,753	3,753	7
8	Accounts Receivable (owners or related parties)	6,465	6,465	8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 479,889	\$ 479,889	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	69,000	54,000	13
14	Buildings, at Historical Cost	959,500	970,803	14
15	Leasehold Improvements, at Historical Cost		15,671	15
16	Equipment, at Historical Cost	190,227	190,227	16
17	Accumulated Depreciation (book methods)	(82,303)	(101,713)	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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,136,424	\$ 1,128,988	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,616,313	\$ 1,608,877	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 255,216	\$ 255,216	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,805	14,805	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,689	6,689	31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,600	15,600	32
33	Accrued Interest Payable	12,420	12,420	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Additional Withholdings</u>	6,941	6,941	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 311,671	\$ 311,671	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	189,652	189,652	39
40	Mortgage Payable	1,005,111	1,005,111	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,194,763	\$ 1,194,763	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,506,434	\$ 1,506,434	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 109,879	\$ 102,443	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,616,313	\$ 1,608,877	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,806</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,806</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	106,074	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	(1)	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>106,073</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>109,879</b>	<b>24</b> *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/06 Ending: 12/31/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,621,498	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,621,498	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</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		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,194	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,194	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc	705	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 705	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,625,397	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	387,876	31
32	Health Care	547,534	32
33	General Administration	250,266	33
<b>B. Capital Expense</b>			
34	Ownership	244,272	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	49,407	35
36	Provider Participation Fee	39,968	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,519,323	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	106,074	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 106,074	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity is a cash basis taxpayer

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Benton Rehabilitation & Health Care Center**

# **0047407**

Report Period Beginning:

**01/01/06**

Ending:

**12/31/06**

**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	2,033	2,033	\$ 40,545	\$ 19.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,675	1,675	26,358	15.74	3
4	Licensed Practical Nurses	6,543	6,617	95,455	14.43	4
5	CNAs & Orderlies	27,334	27,568	237,101	8.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,121	4,169	43,735	10.49	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,370	11.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,887	9,924	69,244	6.98	15
16	Dishwashers					16
17	Maintenance Workers	2,122	2,122	27,798	13.10	17
18	Housekeepers	9,711	9,733	73,896	7.59	18
19	Laundry	2,200	2,237	15,574	6.96	19
20	Administrator	2,080	2,080	57,760	27.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coordin	3,180	3,180	30,890	9.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,966	73,418	\$ 742,725 *	\$ 10.12	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,600	9,3	36
37	Medical Records Consultant	2 visits	83	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	889	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,572		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	\$ 57,760	Workers' Compensation Insurance	\$ 20,974	IDPH License Fee	\$ 6,832	
				Unemployment Compensation Insurance	39,663	Advertising: Employee Recruitment	534	
				FICA Taxes	54,848	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed <u>142</u> )	1,420	
				Employee Meals	3,517	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	560	
				Employee Retirement	22	Home Office Allocation	928	
				Employee Relations	3,816			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,760					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee (eliminated in Col. 7)			\$ 33,500				Out-of-State Travel	\$
							In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	500
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 33,500	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							TOTAL	
C. Professional Services								
Vendor/Payee	Type	Amount						
LTC Solutions	Computer Services	\$ 1,850						
Verizon North	Computer Services	139						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,989					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Benton Rehabilitation & Health Care Center  
Provider Number - 0046032  
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 1,989

Allocated from Home Office

Other Professional Fees	5,740
Legal	77
Other Professional Fees - PHO	2,363
Legal - PHO	73
Home Office Architect Fee Offset, per Sch VI	<u>(421)</u>

Total (agree to Schedule V, line 19, column 8) 9,821

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5					N/A								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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? N 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? N If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Y  
What was the average life used for new equipment added during this period? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 340 Line 10.2
- (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 N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,968  
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. \$ 3,517 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- 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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**