

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

<p><b>I. IDPH License ID Number:</b> <u>0047407</u></p> <p><b>Facility Name:</b> <u>Benton Rehabilitation &amp; Health Care Center</u></p> <p><b>Address:</b> <u>1409 North Main Street, Box 847</u> <u>Benton</u> <u>62812</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Franklin</u></p> <p><b>Telephone Number:</b> <u>(618)435-2712</u> <b>Fax #</b> <u>(618)435-2105</u></p> <p><b>HFS ID Number:</b> <u>203224201020</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/1/05</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>          </u> </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other <u>                          </u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other <u>                          </u> </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>(309) 691-8113</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>          </u>	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other <u>                          </u>	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other <u>                          </u>	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <span style="float: right;">Phone # (217) 782-1630</span> </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>          </u>	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other <u>                          </u>	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other <u>                          </u>						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____							

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 8/15/07

	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)	11	1,529	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	62	25,116	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	16,617	1,905		18,522	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,617	1,905		18,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.51%

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

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 10/1/05

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 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	97,385	11,241		108,626		108,626	3,729	112,355		1
2	Food Purchase		91,832		91,832		91,832	42	91,874		2
3	Housekeeping	72,473	9,468		81,941		81,941	18	81,959		3
4	Laundry	22,174	8,712		30,886		30,886	1	30,887		4
5	Heat and Other Utilities			69,239	69,239		69,239	265	69,504		5
6	Maintenance	23,265	11,073	17,054	51,392		51,392	2,174	53,566		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							2,525	2,525		7
8	<b>TOTAL General Services</b>	215,297	132,326	86,293	433,916		433,916	8,754	442,670		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	438,242	17,547	546	456,335		456,335	6,659	462,994		10
10a	Therapy			13,551	13,551		13,551		13,551		10a
11	Activities	26	717	1,625	2,368		2,368		2,368		11
12	Social Services	43,714			43,714		43,714		43,714		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							3,042	3,042		15
16	<b>TOTAL Health Care and Programs</b>	481,982	18,264	25,322	525,568		525,568	9,701	535,269		16
	<b>C. General Administration</b>										
17	Administrative	56,641		33,000	89,641		89,641	(12,559)	77,082		17
18	Directors Fees										18
19	Professional Services			7,137	7,137		7,137	5,704	12,841		19
20	Dues, Fees, Subscriptions & Promotions			4,845	4,845		4,845	737	5,582		20
21	Clerical & General Office Expenses		2,408	7,902	10,310		10,310	28,444	38,754		21
22	Employee Benefits & Payroll Taxes			134,461	134,461		134,461		134,461		22
23	Inservice Training & Education							302	302		23
24	Travel and Seminar							482	482		24
25	Other Admin. Staff Transportation			1,630	1,630		1,630	3,134	4,764		25
26	Insurance-Prop.Liab.Malpractice			13,425	13,425		13,425	709	14,134		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							14,938	14,938		27
28	<b>TOTAL General Administration</b>	56,641	2,408	202,400	261,449		261,449	41,891	303,340		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	753,920	152,998	314,015	1,220,933		1,220,933	60,346	1,281,279		29

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

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center

#0047407

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			68,258	68,258		68,258	1,668	69,926			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,281	127,281		127,281	42,462	169,743			32
33	Real Estate Taxes			16,873	16,873		16,873	606	17,479			33
34	Rent-Facility & Grounds							37	37			34
35	Rent-Equipment & Vehicles			22,940	22,940		22,940	488	23,428			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			235,352	235,352		235,352	45,261	280,613			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											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>Non-allowable Cost</b>			982	982		982	(982)				43
44	<b>TOTAL Special Cost Centers</b>			40,950	40,950		40,950	(982)	39,968			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	753,920	152,998	590,317	1,497,235		1,497,235	104,625	1,601,860			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.

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,579)	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	(1,223)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(512)	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	5,275	43		24
25	Fund Raising, Advertising and Promotional	(3,721)	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 Pg. 5A	(776)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,548)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	107,173	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 107,173		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 104,625		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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

Benton Rehabilitation & Health Care Center

ID# 0047407

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset of Miscellaneous Revenue	\$ (331)	21	1
2	Disallowed Special Events	(445)	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
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27				27
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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>	(776)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,550	0	2,179	0	0	0	0	0	0	0	3,729	1
2	Food Purchase	(12)	54	0	0	0	0	0	0	0	0	0	42	2
3	Housekeeping	0	18	0	0	0	0	0	0	0	0	0	18	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	265	0	0	0	0	0	0	0	0	0	265	5
6	Maintenance	0	2,159	0	15	0	0	0	0	0	0	0	2,174	6
7	Other (specify):*	0	707	0	1,818	0	0	0	0	0	0	0	2,525	7
8	<b>TOTAL General Services</b>	(12)	4,754	0	4,012	0	0	0	0	0	0	0	8,754	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	4,098	0	2,561	0	0	0	0	0	0	0	6,659	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	911	0	2,131	0	0	0	0	0	0	0	3,042	15
16	<b>TOTAL Health Care and Programs</b>	0	5,009	0	4,692	0	0	0	0	0	0	0	9,701	16
	<b>C. General Administration</b>													
17	Administrative	0	(21,462)	0	8,903	0	0	0	0	0	0	0	(12,559)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,132	0	2,572	0	0	0	0	0	0	0	5,704	19
20	Fees, Subscriptions & Promotions	0	0	679	58	0	0	0	0	0	0	0	737	20
21	Clerical & General Office Expenses	(331)	0	26,272	2,503	0	0	0	0	0	0	0	28,444	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	302	0	0	0	0	0	0	0	0	302	23
24	Travel and Seminar	0	0	481	1	0	0	0	0	0	0	0	482	24
25	Other Admin. Staff Transportation	0	0	1,742	1,392	0	0	0	0	0	0	0	3,134	25
26	Insurance-Prop.Liab.Malpractice	0	0	709	0	0	0	0	0	0	0	0	709	26
27	Other (specify):*	0	0	7,512	7,426	0	0	0	0	0	0	0	14,938	27
28	<b>TOTAL General Administration</b>	(331)	(18,330)	37,697	22,855	0	0	0	0	0	0	0	41,891	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(343)	(8,567)	37,697	31,559	0	0	0	0	0	0	0	60,346	29

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,223)	0	1,840	1,051	0	0	0	0	0	0	0	1,668	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3,198	39,264	0	0	0	0	0	0	0	42,462	32
33	Real Estate Taxes	0	0	606	0	0	0	0	0	0	0	0	606	33
34	Rent-Facility & Grounds	0	0	37	0	0	0	0	0	0	0	0	37	34
35	Rent-Equipment & Vehicles	0	0	488	0	0	0	0	0	0	0	0	488	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,223)</b>	<b>0</b>	<b>6,169</b>	<b>40,315</b>	<b>0</b>	<b>45,261</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):*	(982)	0	0	0	0	0	0	0	0	0	0	(982)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(982)</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>(982)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(2,548)</b>	<b>(8,567)</b>	<b>43,866</b>	<b>71,874</b>	<b>0</b>	<b>104,625</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	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,550	\$ 1,550	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	54	54	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	265	265	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,159	2,159	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	707	707	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,098	4,098	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%	911	911	10
11	V	17 Administrative	33,000	Petersen Health Care, Inc.	100.00%	11,538	(21,462)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,132	3,132	12
13	V							13
14	Total		\$ 33,000			\$ 24,433	\$ * (8,567)	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	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 2,179	\$	2,179	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	15		15	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,818		1,818	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,561		2,561	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,131		2,131	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	8,903		8,903	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,572		2,572	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	58		58	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,503		2,503	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	1		1	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	1,392		1,392	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	7,426		7,426	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,051		1,051	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	39,264		39,264	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 71,874	\$ *	71,874	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	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 679	\$	679	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	26,272		26,272	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	302		302	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	481		481	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,742		1,742	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	709		709	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,512		7,512	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,840		1,840	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,198		3,198	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	606		606	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	37		37	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	488		488	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		\$			\$ 43,866	\$ *	43,866	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		\$			\$	\$	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	\$ *

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center # 0047407 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	0.76	1.38	Salary	\$ 11,538	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	\$ 11,538		13

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

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	1,316,550	66	\$ 110,171	\$ 109,587	18,522	\$ 1,550	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	18,522	54	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	18,522	18	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	18,522	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	18,522	265	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	18,522	2,159	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	18,522	707	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	18,522	4,098	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	18,522	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	18,522	911	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	18,522	11,538	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	18,522	3,132	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	18,522	679	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	18,522	26,272	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	18,522	302	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	18,522	481	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	18,522	1,742	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	18,522	709	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	18,522	7,512	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	18,522	1,840	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	18,522	3,198	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	18,522	606	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	18,522	37	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	18,522	488	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 68,299	25

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	18,522	\$ 2,179	1
2	2	Food	Resident Days	440,525	23			18,522		2
3	3	Housekeeping	Resident Days	440,525	23			18,522		3
4	4	Laundry	Resident Days	440,525	23			18,522		4
5	5	Utilities	Resident Days	440,525	23			18,522		5
6	6	Maintenance	Resident Days	440,525	23	358		18,522	15	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		18,522	1,818	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	18,522	2,561	8
9	10A	Therapy	Resident Days	440,525	23			18,522		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		18,522	2,131	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	18,522	8,903	11
12	19	Professional Services	Resident Days	440,525	23	61,162		18,522	2,572	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		18,522	58	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		18,522	2,503	14
15	23	Inservice Training & Education	Resident Days	440,525	23			18,522		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		18,522	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		18,522	1,392	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			18,522		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		18,522	7,426	19
20	30	Depreciation	Resident Days	440,525	23	24,996		18,522	1,051	20
21	32	Interest	Resident Days	440,525	23	933,842		18,522	39,264	21
22	33	Real Estate Taxes	Resident Days	440,525	23			18,522		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			18,522		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			18,522		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 71,874	25

Facility Name &amp; ID Number

Benton Rehabilitation &amp; Health Care Center

# 0047407

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 1,600,000	\$ 1,588,946	12/31/13	Varies	\$ 127,281	1				
2												2				
3							Home Office Allocation-PHC				3,198	3				
4							Home Office Allocation-PHO				39,264	4				
5												5				
	<b>Working Capital</b>															
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 1,600,000	\$ 1,588,946			\$ 169,743	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>						\$ 1,600,000	\$ 1,588,946			\$ 169,743	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2006 report.		\$	<b>15,600</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.)	2006	\$	<b>15,973</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	373	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>16,500</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>Home Office Allocation</b>			<b>606</b>	
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>17,479</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002		8
	2003		9
	2004		10
	2005	<b>15,545</b>	11
	2006	<b>15,973</b>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Benton Rehabilitation & Health Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0047407

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(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>Long-Term Care Facility</u>	\$ <u>15,789.48</u>	\$ <u>15,789.48</u>
2. <u>08-07-382-005</u>	<u>Long-Term Care Facility</u>	\$ <u>183.42</u>	\$ <u>183.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>15,972.90</u>	\$ <u>15,972.90</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,200 B. General Construction Type: Exterior Brick & Block Frame Masonry Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 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>Facility</u>	<u>122,404</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>122,404</b>		<b>\$ 54,000</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	73	2005	1968	\$ 959,500	\$	25	\$ 38,379	\$ 38,379	\$ 95,950
5									
6									
7	Home Office Allocation			10,326			252	252	
8									
<b>Improvement Type**</b>									
9	Original Land Improvements	2005		15,000		15	1,000	1,000	2,500
10	Smoke Alarms	2007		2,341		10	117	117	117
11	Interior Signage	2007		3,678		10	184	184	184
12	Canopy	2007		3,572		10	179	179	179
13									
14									
15									
16	Building Booked				38,405			(38,405)	
17	Building Improvement Booked				1,434			(1,434)	
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			691			41	41	
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 995,108	\$ 39,839		\$ 40,152	\$ 313	\$ 98,930	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 190,227	\$ 28,419	\$ 27,176	\$ (1,243)	7	\$ 69,261	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,598	2,598			74
75	TOTALS	\$ 190,227	\$ 28,419	\$ 29,774	\$ 1,355		\$ 69,261	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 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)	\$ 1,239,335	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,258	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,926	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,668	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 168,191	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.

Benton Rehabilitation & Health Care Center  
0047407

Period Beginning 01/01/2007

Period End 12/31/2007

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 18,802
Dishwasher	571
Copier	3,567
Home Office Allocation	488
	<u>23,428</u>

**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		<u>Home Office Allocation</u>			<u>37</u>			6
7	TOTAL				\$ <u>37</u>			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 23,428 Description: See 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

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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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.

**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	\$	541	\$ 8,116	\$	541	\$ 8,116	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6	85		6	85	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		357	5,350		357	5,350	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									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	904	\$ 13,551	\$ 0	904	\$ 13,551	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

# **0047407**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

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

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 657,166	\$ 657,166	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	259,667	259,667	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,921	10,921	6
7	Other Prepaid Expenses	4,817	4,817	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 932,571	\$ 932,571	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	969,826	14
15	Leasehold Improvements, at Historical Cost	9,590	25,282	15
16	Equipment, at Historical Cost	190,227	190,227	16
17	Accumulated Depreciation (book methods)	(150,561)	(168,191)	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 (sum of lines 11 thru 23)</b>	\$ 1,077,756	\$ 1,071,144	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,010,327	\$ 2,003,715	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 180,765	\$ 180,765	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,249	15,249	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,319	5,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,500	16,500	32
33	Accrued Interest Payable	9,933	9,933	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	11,399	11,399	36
37	<u>Due to Related Party</u>	14,724	14,724	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 253,889	\$ 253,889	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,588,946	1,588,946	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P-Prior Owner</u>	103	103	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,589,049	\$ 1,589,049	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,842,938	\$ 1,842,938	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 167,389	\$ 160,777	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,010,327	\$ 2,003,715	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>109,879</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Cost Report Audit Adjustments</b>	<b>(6,269)</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>103,610</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>63,779</b>	<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>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>63,779</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>167,389</b>	<b>24</b> *

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

Benton Rehabilitation & Health Care Center  
0047407  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 18A**

**XVI. Statement of Changes in Equity**

**Beginning Equity Restatements:**

**Post Cost Report Audit Adjustments**

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

**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	\$ 1,560,671	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,560,671	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	12	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>	\$ 12	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	331	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 331	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,561,014	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	433,916	31
32	Health Care	525,568	32
33	General Administration	261,449	33
	<b>B. Capital Expense</b>		
34	Ownership	235,352	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	982	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>	\$ 1,497,235	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	63,779	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 63,779	43

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

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

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

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

Facility Name & ID Number Benton Rehabilitation & Health Care Center

# 0047407

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	\$ 42,792	\$ 20.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,231	2,383	36,538	15.33	3
4	Licensed Practical Nurses	6,437	6,675	92,032	13.79	4
5	CNAs & Orderlies	27,179	27,752	235,200	8.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3	3	26	8.67	9
10	Activity Assistants					10
11	Social Service Workers	4,072	4,144	43,714	10.55	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,579	11.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,899	11,186	72,806	6.51	15
16	Dishwashers					16
17	Maintenance Workers	1,705	1,769	23,265	13.15	17
18	Housekeepers	9,147	9,466	72,473	7.66	18
19	Laundry	2,760	2,892	22,174	7.67	19
20	Administrator	2,080	2,080	56,641	27.23	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 C: <u>Care Plan Coord.</u>	2,080	2,144	31,680	14.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,753	74,654	\$ 753,920 *	\$ 10.10	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			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 546	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)	\$ 10,146		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



**Benton Rehabilitation & Health Care Center**

**0047407**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
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Total (agree to Schedule V, line 19, column 3)		7,137
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**Home Office Allocation**

Pearl & Associates	Legal	20
Addy Bush & Assoc	Legal	10
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	45
Duane Morris	Legal	70
Ginoli & Co.	Accountants	2,306
RSM McGladrey	Accountants	124
McGladrey & Pullen	Accountants	189
Emdeon Business Services	Computer Services	49
Advanced Answers on Demand	Computer Services	1,328
Access 2 Go	Computer Services	100
Ivans	Computer Services	445
Kemper Technology	Computer Services	208
Administar Federal	Computer Services	26
Logmein	Computer Services	16
E-Health Data Solutions	Computer Services	130
Miscellaneous Vendors	Computer Services	19
Julie Breedlove	Computer Services	15
Amerisearch	Employment Fees	602

Total (agree to Schedule V, line 19, column 8)		<u>12,841</u>
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Facility Name & ID Number Benton Rehabilitation & Health Care Center# 0047407Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$2,043
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 114 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12
- (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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees