

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0047407 Facility Name: Benton Rehab & Hlth Care Ctr Address: 1409 N Main St Bx847 Benton 62812 County: Franklin Telephone Number: (618)435-2712 Fax #: (618)435-2105 HFS ID Number: Date of Initial License for Current Owners: 10/1/2005 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Mike Kocher Telephone Number: (309) 673-3009 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Mark B. Petersen (Title) Chief Executive Officer Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Benton Rehab & Hlth Care Ctr

0047407 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>1,861</u>	<u>1,056</u>	<u>2,917</u>	8
9	SNF/PED					9
10	ICF	<u>7,515</u>			<u>7,515</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,515</u>	<u>1,861</u>	<u>1,056</u>	<u>10,432</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.66%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☒ NO ☐

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

YES ☐ NO ☐

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

Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 929

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	125,011	7,521	1,475	134,007		134,007	2,143	136,150			1
2	Food Purchase		65,622		65,622		65,622	(54)	65,568			2
3	Housekeeping	77,344	8,639		85,983		85,983	37	86,020			3
4	Laundry		4,647		4,647		4,647		4,647			4
5	Heat and Other Utilities			48,950	48,950		48,950		48,950			5
6	Maintenance	31,046	8,017	20,249	59,312		59,312	557	59,869			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	233,401	94,446	70,674	398,521		398,521	2,683	401,204			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	510,960	54,815	3,458	569,233		569,233	(708)	568,525			10
10a	Therapy			137,342	137,342		137,342		137,342			10a
11	Activities	20,947	50	3,021	24,018		24,018		24,018			11
12	Social Services	28,395			28,395		28,395		28,395			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	560,302	54,865	153,421	768,588		768,588	(708)	767,880			16
	C. General Administration											
17	Administrative			155,500	155,500		155,500	(101,480)	54,020			17
18	Directors Fees											18
19	Professional Services			(473)	(473)		(473)	15,550	15,077			19
20	Dues, Fees, Subscriptions & Promotions			4,959	4,959		4,959	228	5,187			20
21	Clerical & General Office Expenses		956	8,583	9,539		9,539	25,536	35,075			21
22	Employee Benefits & Payroll Taxes			106,444	106,444		106,444	15,138	121,582			22
23	Inservice Training & Education							48	48			23
24	Travel and Seminar							23	23			24
25	Other Admin. Staff Transportation			7,198	7,198		7,198	1,965	9,163			25
26	Insurance-Prop.Liab.Malpractice			16,692	16,692		16,692	21,593	38,285			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration		956	298,903	299,859		299,859	(21,399)	278,460			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	793,703	150,267	522,998	1,466,968		1,466,968	(19,424)	1,447,544			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			975	975		975	55,900	56,875			30
31	Amortization of Pre-Op. & Org.							10,892	10,892			31
32	Interest							113,765	113,765			32
33	Real Estate Taxes							19,040	19,040			33
34	Rent-Facility & Grounds			306,992	306,992		306,992	(306,992)				34
35	Rent-Equipment & Vehicles			28,626	28,626		28,626	449	29,075			35
36	Other (specify):*											36
37	TOTAL Ownership			336,593	336,593		336,593	(106,946)	229,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,139		39,139		39,139		39,139			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,332	94,332		94,332		94,332			42
43	Other (specify):*		631	40,665	41,296		41,296	(41,296)				43
44	TOTAL Special Cost Centers		39,770	134,997	174,767		174,767	(41,296)	133,471			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	793,703	190,037	994,588	1,978,328		1,978,328	(167,666)	1,810,662			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(93)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,195)	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	958	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,025)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,600)	43		24
25	Fund Raising, Advertising and Promotional	(1,414)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(6,816)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,203)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(126,463)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (126,463)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (167,666)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,833)	43	1
2	X-Rays-Part A	(2,962)	43	2
3	To offset Nursing Supplies Revenue	(771)	10	3
4	Disallowed Special Events	(250)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,816)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2,143	0	0	0	0	0	0	0	0	0	2,143	1
2	Food Purchase	(93)	39	0	0	0	0	0	0	0	0	0	(54)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	125	0	0	432	0	0	0	0	0	0	557	6
7	Other (specify):*	0	1,170	0	0	0	0	0	0	0	0	0	1,170	7
8	TOTAL General Services	(93)	3,514	0	0	432	0	0	0	0	0	0	3,853	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(771)	63	0	0	0	0	0	0	0	0	0	(708)	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(771)	63	0	0	0	0	0	0	0	0	0	(708)	16
	C. General Administration													
17	Administrative	0	(101,480)	0	0	0	0	0	0	0	0	0	(101,480)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,457	0	5,773	4,320	0	0	0	0	0	0	15,550	19
20	Fees, Subscriptions & Promotions	0	0	228	0	0	0	0	0	0	0	0	228	20
21	Clerical & General Office Expenses	0	0	24,981	0	555	0	0	0	0	0	0	25,536	21
22	Employee Benefits & Payroll Taxes	0	0	13,968	0	0	0	0	0	0	0	0	13,968	22
23	Inservice Training & Education	0	0	48	0	0	0	0	0	0	0	0	48	23
24	Travel and Seminar	0	0	23	0	0	0	0	0	0	0	0	23	24
25	Other Admin. Staff Transportation	0	0	1,965	0	0	0	0	0	0	0	0	1,965	25
26	Insurance-Prop.Liab.Malpractice	0	0	277	0	21,316	0	0	0	0	0	0	21,593	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(96,023)	41,490	5,773	26,191	0	0	0	0	0	0	(22,569)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(864)	(92,446)	41,490	5,773	26,623	0	0	0	0	0	0	(19,424)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	958	0	5,528	697	48,717	0	0	0	0	0	0	55,900	30
31	Amortization of Pre-Op. & Org.	0	0	0	1,277	9,615	0	0	0	0	0	0	10,892	31
32	Interest	(1)	0	162	8,699	104,905	0	0	0	0	0	0	113,765	32
33	Real Estate Taxes	0	0	127	0	18,913	0	0	0	0	0	0	19,040	33
34	Rent-Facility & Grounds	0	0	0	0	(306,992)	0	0	0	0	0	0	(306,992)	34
35	Rent-Equipment & Vehicles	0	0	449	0	0	0	0	0	0	0	0	449	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	957	0	6,266	10,673	(124,842)	0	0	0	0	0	0	(106,946)	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(41,296)	0	0	0	0	0	0	0	0	0	0	(41,296)	43
44	TOTAL Special Cost Centers	(41,296)	0	0	0	0	0	0	0	0	0	0	(41,296)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,203)	(92,446)	47,756	16,446	(98,219)	0	0	0	0	0	0	(167,666)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		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 Management, Inc.	100.00%	\$ 2,143	\$ 2,143	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	39	39	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	37	37	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	0		4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	125	125	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	1,170	1,170	6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	63	63	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	155,500	Petersen Health Care Management, Inc.	100.00%	54,020	(101,480)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	5,457	5,457	12
13	V								13
14	Total			\$ 155,500			\$ 63,054	\$ * (92,446)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 228	\$ 228	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	24,981	24,981	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,968	13,968	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	48	48	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	23	23	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,965	1,965	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	277	277	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	5,528	5,528	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	162	162	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	127	127	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	449	449	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			\$			\$ 47,756	\$ * 47,756	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	5,773	5,773	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	697	697	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	1,277	1,277	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	8,699	8,699	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			\$			\$ 16,446	\$ * 16,446	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	6	Mainteance	\$	Benton Land, LLC	100.00%	\$ 432	\$	432 15
16	V	19	Professional Services	\$	Benton Land, LLC	100.00%	\$ 4,320	\$	4,320 16
17	V	21	Equipment		Benton Land, LLC	100.00%	555		555 17
18	V	26	Insurance-Property		Benton Land, LLC	100.00%	3,408		3,408 18
19	V	26	Insurance-Mortgage Insurance		Benton Land, LLC	100.00%	17,908		17,908 19
20	V	30	Depreciation		Benton Land, LLC	100.00%	48,717		48,717 20
21	V	31	Amortization		Benton Land, LLC	100.00%	9,615		9,615 21
22	V	32	Interest	1,176	Benton Land, LLC	100.00%	106,081		104,905 22
23	V	33	Real Estate Taxes		Benton Land, LLC	100.00%	18,913		18,913 23
24	V	34	Rent-Income and Grounds	306,992	Benton Land, LLC	100.00%			(306,992) 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	Total			\$ 308,168			\$ 209,949	\$ *	(98,219) 39

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

Facility Name & ID Number

Benton Rehab & Hlth Care Ctr

0047407

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Benton Rehab & Hlth Care Ctr

0047407

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Benton Rehab & Hlth Care Ctr

0047407

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Benton Rehab & Hlth Care Ctr # 0047407 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	10,432	\$ 2,143	1
2	2	Food	Resident Days	75	5,673	0	10,432	39	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	10,432	37	3
4	5	Utilities	Resident Days	75	18,209	0	10,432	0	4
5	6	Maintenance	Resident Days	75	170,632	137,057	10,432	125	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,432	1,170	6
7	9	Medical Director	Resident Days	75	0	0	10,432	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	10,432	63	8
9	10A	Therapy	Resident Days	75	0	0	10,432	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,432	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	10,432	54,020	11
12	19	Professional Services	Resident Days	75	795,918	0	10,432	5,457	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	10,432	228	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	10,432	24,981	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	10,432	13,968	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	10,432	48	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	10,432	23	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	10,432	1,965	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	10,432	277	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,432	0	20
21	30	Depreciation	Resident Days	75	806,271	0	10,432	5,528	21
22	32	Interest	Resident Days	75	23,686	0	10,432	162	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	10,432	127	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	10,432	449	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 110,810	25

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

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	197,666	9	\$	\$	10,432	\$	1
2	2	Food	Resident Days	197,666	9			10,432		2
3	3	Housekeeping	Resident Days	197,666	9			10,432		3
4	4	Laundry	Resident Days	197,666	9			10,432		4
5	5	Utilities	Resident Days	197,666	9			10,432		5
6	6	Maintenance	Resident Days	197,666	9			10,432		6
7	7	Mgmt. Allocation of Benefits	Resident Days	197,666	9			10,432		7
8	10	Nursing and Medical Records	Resident Days	197,666	9			10,432		8
9	15	Mgmt. Allocation of Benefits	Resident Days	197,666	9			10,432		9
10	17	Administrative	Resident Days	197,666	9			10,432		10
11	19	Professional Services	Resident Days	197,666	9	109,392		10,432	5,773	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	197,666	9			10,432		12
13	21	Clerical and General Office	Resident Days	197,666	9			10,432		13
14	22	Employee Benefits & Payroll	Resident Days	197,666	9			10,432		14
15	23	Inservice Training & Education	Resident Days	197,666	9			10,432		15
16	24	Travel and Seminar	Resident Days	197,666	9			10,432		16
17	25	Other Admin. Staff Transport.	Resident Days	197,666	9			10,432		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	197,666	9			10,432		18
19	30	Depreciation	Resident Days	197,666	9	13,207		10,432	697	19
20	31	Amortization	Resident Days	197,666	9	24,205		10,432	1,277	20
21	32	Interest	Resident Days	197,666	9	164,836		10,432	8,699	21
22	33	Real Estate Taxes	Resident Days	197,666	9			10,432		22
23	34	Rent-Facility and Grounds	Resident Days	197,666	9			10,432		23
24	35	Rent-Equipment & Vehicles	Resident Days	197,666	9			10,432		24
25	TOTALS					\$ 311,640	\$		\$ 16,446	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital Finance		X	Mortgage	Varies	1/1/15	\$ 2,927,200	\$ 2,707,492	12/31/24	Varies	\$ 106,081	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,927,200	\$ 2,707,492			\$ 106,081	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,177)	10
11								Home Office Allocation-PHO			8,699	11
12								Home Office Allocation-PHCM			162	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 7,684	14
15	TOTALS (line 9+line14)						\$ 2,927,200	\$ 2,707,492			\$ 113,765	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 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 2015 report.

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.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ _____ For _____ Tax Year.

Home Office Allocation 127

(Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2011	_____ 17,455	8
2012	_____ 18,008	9
2013	_____ 18,530	10
2014	_____ 18,793	11
2015	_____ 18,853	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Benton Rehab & Hlth Care Ctr COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0047407

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-07-378-005	Long-Term Care Facility	\$ 18,635.74	\$ 18,635.74
2. 08-07-382-005	Long-Term Care Facility	\$ 216.90	\$ 216.90
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 18,852.64	\$ 18,852.64

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

22,200

B. General Construction Type:

Exterior

Brick & Block

Frame

Masonry

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

197,297

2. Number of Years Over Which it is Being Amortized:

20

3. Current Period Amortization:

9,615

4. Dates Incurred:

2012-2013 Loan Costs

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	73		2005	1968	\$ 959,500	\$	25	\$ 38,379	\$ 38,379	\$ 441,361
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2005	15,000		15	1,000	1,000	11,500
10	Smoke Alarms			2007	2,341		10	234	234	2,223
11	Interior Signage			2007	3,678		10	368	368	3,496
12	Canopy			2007	3,572		10	357	357	3,392
13	Air Compressor Repair			2009	2,958		7	209	209	2,958
14	Sprinkler System Replacement			2010	56,828		15	3,788	3,788	24,622
15	Generator			2011	16,755		15	1,117	1,117	2,927
16	Windows			2013	18,111		25	724	724	1,377
17	Gutter Repair			2014	3,043		7	435	435	1,088
18	Concrete Repair			2014	3,000		15	200	200	500
19	Soffit, Facia, and Downspout Replacement			2014	10,454		15	697	697	1,743
20	Water Heater			2015	2,986		7	428	428	642
21	Air Conditioner			2015	3,595		15	240	240	360
22	Roof Repair			2015	1,467		7	210	210	315
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,000			(1,000)	
31	Building Booked					38,405			(38,405)	
32	Building Improvement Booked					8,180			(8,180)	
33										
34	2016-Home Office Allocation-Building Improvements				4,606			111	111	
35	2016-Home Office Allocation-Land Improvements				424			28	28	
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

0047407

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,108,318	\$ 47,585		\$ 48,525	\$ 940	\$ 498,504	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 19,553	\$ 1,644	\$ 1,955	\$ 311	5-10 yrs.	\$ 11,381	71
72	Current Year Purchases	4,324	463	309	(154)	7 yrs.	309	72
73	Fully Depreciated Assets	190,227					190,227	73
74	Home Office Allocation			6,086	6,086			74
75	TOTALS	\$ 214,104	\$ 2,107	\$ 8,350	\$ 6,243		\$ 201,917	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77	N/A								
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	1,376,422
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	49,692
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	56,875
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	7,183
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	700,421

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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								6
7	TOTAL				\$			7

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 29,075 Description: See Attached Schedule 14A
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
 Ending

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

	Fiscal Year Ending	Annual Rent
12.	<u> </u> /2017	\$ <u> </u>
13.	<u> </u> /2018	\$ <u> </u>
14.	<u> </u> /2019	\$ <u> </u>

* If there is an option to buy the building,
 please provide complete details on attached
 schedule.

** This amount plus any amortization of lease
 expense must agree with page 4, line 34.

Benton Rehab & Hlth Care Ctr
0047407

Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	24,010
Dishwasher		701
Copier		3,915
Home Office Allocation		449
		<u>29,075</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

		1	2	3	4	5	6	7	8	
	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	\$	2,943	\$ 44,151	\$	2,943	\$ 44,151	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		828	12,423		828	12,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,385	80,768		5,385	80,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				39,139		39,139	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,156	\$ 137,342	\$ 39,139	9,156	\$ 176,481	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,662,435)	\$ (1,662,435)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,136)	1,095,385	1,095,385	3
4	Supply Inventory (priced at Cost)	6,305	6,305	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,128	33,890	6
7	Other Prepaid Expenses		25,017	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	2,434	2,434	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (539,183)	\$ (499,404)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		54,000	13
14	Buildings, at Historical Cost		964,106	14
15	Leasehold Improvements, at Historical Cost		144,212	15
16	Equipment, at Historical Cost	6,824	214,104	16
17	Accumulated Depreciation (book methods)	(1,640)	(700,421)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		192,297	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,633)	20
21	Restricted Funds		417,771	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,184	\$ 1,264,436	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (533,999)	\$ 765,032	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 312,609	\$ 312,609	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,259	40,259	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,634	18,634	31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,416	32
33	Accrued Interest Payable		8,687	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	159,379	159,379	36
37	Accrued Management Fees	20,096	20,096	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 550,977	\$ 579,080	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,707,492	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,648,977	(13,039)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,648,977	\$ 2,694,453	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,199,954	\$ 3,273,533	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,733,953)	\$ (2,508,501)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (533,999)	\$ 765,032	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,424,108)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(1,531)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,425,639)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(308,314)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (308,314)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,733,953)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Benton Rehab & Hlth Care Ctr

0047407

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,518,648	1
2	Discounts and Allowances for all Levels	(176,740)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,341,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,108	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 236,108	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	93	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,175	20
21	Other Medical Services	11,431	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 91,226	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Revenue	771	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 771	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,670,014	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	398,521	31
32	Health Care	768,588	32
33	General Administration	299,859	33
	B. Capital Expense		
34	Ownership	336,593	34
	C. Ancillary Expense		
35	Special Cost Centers	80,435	35
36	Provider Participation Fee	94,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,978,328	40
41	Income before Income Taxes (line 30 minus line 40)**	(308,314)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (308,314)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 936,719	44
45	Private Pay - Net Inpatient Revenue	246,429	45
46	Medicare - Net Inpatient Revenue	144,386	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	14,374	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,341,908	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	2,057	59,585	\$ 28.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,979	5,295	93,747	17.70	3
4	Licensed Practical Nurses	6,599	6,986	114,539	16.40	4
5	CNAs & Orderlies	20,653	21,369	209,835	9.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	20,947	10.07	9
10	Activity Assistants					10
11	Social Service Workers	1,341	1,341	28,395	21.17	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,624	15.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,589	10,118	93,387	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,020	2,147	31,046	14.46	17
18	Housekeepers	8,427	8,697	77,344	8.89	18
19	Laundry					19
20	Administrator	2,080	2,080	54,020	25.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CPC	1,893	1,901	33,254	17.49	33
34	TOTAL (lines 1 - 33)	63,734	66,151	\$ 847,723 *	\$ 12.81	34

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	25	\$ 1,475	L1, C3	35
36	Medical Director	Monthly	9,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,294	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	25	\$ 13,369		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Benton Rehab & Hlth Care Ctr

#

0047407

Report Period Beginning:

1/1/2016

Page 21

Ending:

12/31/2016

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	
Tracy Garrett	Administrator	0	17,270	Workers' Compensation Insurance	\$ 23,090	IDPH License Fee	\$ 1,990	
Jeremy Biggerstaff	Administrator	0	36,750	Unemployment Compensation Insurance	20,792	Advertising: Employee Recruitment		
				FICA Taxes	60,104	Health Care Worker Background Check		
				Employee Health Insurance	2,014	(Indicate # of checks performed 9)	161	
				Employee Meals		Patient Background Checks 32	573	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	251	
				Employee Relations	444	Miscellaneous Dues & Subscriptions	1,984	
				Home Office Allocation	15,138	Home Office Allocation	228	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 54,020					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 155,500			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 155,500	TOTAL (agree to Schedule V, line 22, col.8)	\$ 121,582	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,187	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		\$ 2,941					
Frontier	Computer Services		731					
Honkamp Krueger & Co.	Accounting Fees		73	N/A				
Ability Network	Computer Services		102				In-State Travel	
Capital Finance Group	Refund of Refinancing Fees		(4,320)					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ (473)				Home Office Allocation	23
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 23

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Benton Rehab & Hlth Care Ctr
0047407

Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(473)
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	24
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	42
Healthcare Resources International	Legal	210
Hunziker Law	Legal	50
Lexis Nexis	Legal	4
Illinois Secretary of State	Legal	15
Lane and Waterman	Legal	86
Quinn and Johnston	Legal	382
Peoria County Recorder	Legal	11
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	219
Ginoli & Co.	Accountants	3,040
Capital Finance Group	Accountants	4,755
Miscellaneous	Computer Services	28
Change Healthcare	Computer Services	4
PTC Select	Computer Services	2
Advanced Answers on Demand	Computer Services	1,921
Stratus Networks	Computer Services	195
Kemper Technology	Computer Services	129
AT&T	Computer Services	3
Ability Network	Computer Services	819
CIAN	Computer Services	98
Comcast	Computer Services	16
CCH	Computer Services	6
Charter Communications	Computer Services	19
Allscripts	Computer Services	286
ATS	Computer Services	129
Allpayer Exchange	Computer Services	6
Optimizer	Other Prof Fees	20
Ankura	Other Prof Fees	149
David Budde	Other Prof Fees	17
Bruner, Cooper, Zuck	Other Prof Fees	43
Marotta, Gund, Budd, Dzerda	Other Prof Fees	2,537
Professional Software and Services	Other Prof Fees	11
Hughes Valuation Services	Other Prof Fees	13
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8) 15,077

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>IHCA-\$1,000</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>No</u> <u>N/A</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>7 yrs.</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>10,474</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>94,332</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>93</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>Adequate records have been maintained.</u> <u>Yes</u> <u>Yes</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>Ginoli and Company</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees	<u>N/A</u>

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detr	-167,666	equal to	-167,666	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	113,765	equal to	113,765	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	19,040	equal to	19,040	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	9,615	equal to	10,892	-1,277	FAILED	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	56,875	equal to	56,875	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	29,075	equal to	29,075	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	137,342	equal to	137,342	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	39,139	equal to	39,139	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	398,521	equal to	398,521	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	768,588	equal to	768,588	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	299,859	equal to	299,859	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	336,593	equal to	336,593	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	80,435	equal to	80,435	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pri	94,332	equal to	94,332	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	510,960	equal to	510,960	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	20,947	equal to	20,947	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	28,395	equal to	28,395	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	125,011	equal to	125,011	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	31,046	equal to	31,046	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	77,344	equal to	77,344	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	54,020	equal to	54,020	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		#VALUE!	#VALUE!	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	847,723	equal to	793,703	54,020	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	1,475	< or = to	1,475	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,600	< or = to	9,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	2,294	< or = to	3,458	-1,164	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	3,021	-3,021	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	54,020	equal to	54,020	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	155,500	equal to	155,500	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	-473	equal to	-473	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	121,582	equal to	121,582	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	5,187	equal to	5,187	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	23	equal to	23	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	94,332	equal to	94,332	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	929	equal to	1,056	-127	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-126,463	equal to	-126,463	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	2,707,492	equal to	2,707,492	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	19,416	equal to	19,416	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	54,000	equal to	54,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,108,318	equal to	1,108,318	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	214,104	equal to	214,104	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	700,421	equal to	700,421	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equi	-2,733,953	equal to	-2,733,953	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los)	-308,314	equal to	-308,314	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	-533,999	equal to	-533,999	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	125,011	7,521	1,475	134,007	0	134,007	2,143	136,150
2. Food Purchase	0	65,622	0	65,622	0	65,622	-54	65,568
3. Housekeeping	77,344	8,639	0	85,983	0	85,983	37	86,020
4. Laundry	0	4,647	0	4,647	0	4,647	0	4,647
5. Heat and Other Utilities	0	0	48,950	48,950	0	48,950	0	48,950
6. Maintenance	31,046	8,017	20,249	59,312	0	59,312	557	59,869
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	233,401	94,446	70,674	398,521	0	398,521	2,683	401,204
9. Medical Director	0	0	9,600	9,600	0	9,600	0	9,600
10. Nursing & Medical Records	510,960	54,815	3,458	569,233	0	569,233	-708	568,525
10a. Therapy	0	0	137,342	137,342	0	137,342	0	137,342
11. Activities	20,947	50	3,021	24,018	0	24,018	0	24,018
12. Social Services	28,395	0	0	28,395	0	28,395	0	28,395
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	560,302	54,865	153,421	768,588	0	768,588	-708	767,880
17. Administrative	0	0	155,500	155,500	0	155,500	-101,480	54,020
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	-473	-473	0	-473	15,550	15,077
20. Fees, Subscriptions & Promotion	0	0	4,959	4,959	0	4,959	228	5,187
21. Clerical & General Office	0	956	8,583	9,539	0	9,539	25,536	35,075
22. Employee Benefits & Payroll	0	0	106,444	106,444	0	106,444	15,138	121,582
23. Inservice Training & Education	0	0	0	0	0	0	48	48
24. Travel and Seminar	0	0	0	0	0	0	23	23
25. Other Admin. Staff Trans	0	0	7,198	7,198	0	7,198	1,965	9,163
26. Insurance-Prop.Liab.Malpractice	0	0	16,692	16,692	0	16,692	21,593	38,285
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	956	298,903	299,859	0	299,859	-21,399	278,460
29. Total General Administrative	793,703	150,267	522,998	1,466,968	0	1,466,968	-19,424	#####
30. Depreciation	0	0	975	975	0	975	55,900	56,875
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	10,892	10,892
32. Interest	0	0	0	0	0	0	113,765	113,765
33. Real Estate	0	0	0	0	0	0	19,040	19,040
34. Rent - Facility & Grounds	0	0	306,992	306,992	0	306,992	-306,992	0
35. Rent - Equipment & Vehicles	0	0	28,626	28,626	0	28,626	449	29,075
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	336,593	336,593	0	336,593	-106,946	229,647
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	39,139	0	39,139	0	39,139	0	39,139
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	94,332	94,332	0	94,332	0	94,332
43. Other (specify):*	0	631	40,665	41,296	0	41,296	-41,296	0
44. Total Special Cost Ce	0	39,770	134,997	174,767	0	174,767	-41,296	133,471
45. Grand Total	793,703	190,037	994,588	1,978,328	0	1,978,328	-167,666	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#####	-1,662,435
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,095,385	1,095,385
4. Supply Inventory	6,305	6,305
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,128	33,890
7. Other Prepaid Expenses	0	25,017
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	2,434	2,434
10. Total current assets	-539,183	-499,404
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	54,000
14. Buildings, at Historical Cost	0	964,106
15. Leasehold Improvements, Historical Cost	0	144,212
16. Equipment, at Historical Cost	6,824	214,104
17. Accumulated Depreciation (book methods)	-1,640	-700,421
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	192,297
20. Accum Amort - Org/Pre-Op Costs	0	-21,633
21. Restricted Funds	0	417,771
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	5,184	1,264,436
25. Total Assets	-533,999	765,032
CURRENT LIABILITIES		
26. Accounts Payable	312,609	312,609
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	40,259	40,259
31. Accrued Taxes Payable	18,634	18,634
32. Accrued Real Estate Taxes	0	19,416
33. Accrued Interest Payable	0	8,687
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	159,379	159,379
37. Other Current Liabilities (specify):	20,096	20,096
38. Total Current Liabilities	550,977	579,080
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,707,492
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,648,977	-13,039
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,648,977	2,694,453
46.Total Liabilities	2,199,954	3,273,533
47.Total Equity	#####	-2,508,501
48.Total Liabilities and Equity	-533,999	765,032

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,518,648
2. Discounts and Allowances for all Levels	-176,740
Subtotal - Inpatient Care	1,341,908
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	236,108
7. Oxygen	0
Subtotal - Ancillary Revenue	236,108
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	93
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	72,527
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	7,175
21. Other Medical Services	11,431
22. Laundry	0
Subtotal - Other Operating Revenue	91,226
24. Contributions	0
25. Interest and Other Investments Income	1
Subtotal - Non-Operating Revenue	1
27. Other Revenue (specify):	0
28. Other Revenue (specify):	771
Subtotal - Other Revenue	771
30. Total Revenue	1,670,014
31. General Services	406,823
32. Health Care	808,669
33. General Administration	358,053
34. Ownership	329,124
35. Special Cost Centers	208,587
35. Provider Participation Fee	102,979
37. Other	0
40. Total Expenses	2,214,235
41. Income Before Income Taxes	-544,221
42. Income Taxes	0
43. Net Income or Loss for the Year	-544,221