

			FOR OHF USE			

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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>I. IDPH Facility ID Number: <u>0047142</u></p> <p>Facility Name: <u>ALEDO REHAB & HEALTH CARE CENTER</u></p> <p>Address: <u>304 SW 12TH STREET</u> <u>ALEDO</u> <u>61231</u> Number City Zip Code</p> <p>County: <u>MERCER</u></p> <p>Telephone Number: <u>309-582-5376</u> Fax # <u>309-582-2435</u></p> <p>IDPA ID Number: <u>200349783006</u></p> <p>Date of Initial License for Current Owners: <u>5/1/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/01/2005</u> to <u>12/31/2005</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: 2px;">Officer or Administrator of Provider</td> <td style="padding: 2px;">(Signed) _____ (Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td style="padding: 2px;">Paid Preparer</td> <td style="padding: 2px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____							
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER

0047142 Report Period Beginning: 05/01/2005 Ending: 12/31/2005

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	80	Skilled (SNF)	80	19,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	19,600	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	9,857	4,356	698	14,911	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,857	4,356	698	14,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.08%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location
Date started 5/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 698

Medicare Intermediary Not yet determined

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENT # 0047142 Report Period Beginning: 05/01/2005 Ending: 12/31/2005**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	69,358	9,415	901	79,674		79,674	1,793	81,467		1
2	Food Purchase		74,959		74,959		74,959	(4,117)	70,842		2
3	Housekeeping	57,606	12,960		70,566		70,566	41	70,607		3
4	Laundry	28,963	10,982		39,945		39,945	3	39,948		4
5	Heat and Other Utilities			40,316	40,316		40,316	296	40,612		5
6	Maintenance	17,326	28,452	11,396	57,174		57,174	2,353	59,527		6
7	Other (specify):* Home Office Benefits							512	512		7
8	TOTAL General Services	173,253	136,768	52,613	362,634		362,634	881	363,515		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	489,916	31,494	583	521,993		521,993	2,967	524,960		10
10a	Therapy		615	33,136	33,751		33,751	2	33,753		10a
11	Activities	31,492	983	2,673	35,148		35,148		35,148		11
12	Social Services	20,839	473		21,312		21,312		21,312		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							411	411		15
16	TOTAL Health Care and Programs	542,247	33,565	40,392	616,204		616,204	3,380	619,584		16
	C. General Administration										
17	Administrative	29,404		20,000	49,404		49,404	(7,297)	42,107		17
18	Directors Fees										18
19	Professional Services			3,551	3,551		3,551	4,953	8,504		19
20	Dues, Fees, Subscriptions & Promotion			3,205	3,205		3,205	3,329	6,534		20
21	Clerical & General Office Expense	5,278	6,288	6,491	18,057		18,057	17,120	35,177		21
22	Employee Benefits & Payroll Tax			94,557	94,557		94,557	3,683	98,240		22
23	Inservice Training & Education			803	803		803	266	1,069		23
24	Travel and Semina			251	251		251	365	616		24
25	Other Admin. Staff Transportation			4,242	4,242		4,242	1,572	5,814		25
26	Insurance-Prop.Liab.Malpractice			20,991	20,991		20,991	485	21,476		26
27	Other (specify):* Home Office Benefits							3,646	3,646		27
28	TOTAL General Administration	34,682	6,288	154,091	195,061		195,061	28,122	223,183		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	750,182	176,621	247,096	1,173,899		1,173,899	32,383	1,206,282		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,368	36,368		36,368	8,052	44,420			30
31	Amortization of Pre-Op. & Org											31
32	Interest			77,138	77,138		77,138	7,266	84,404			32
33	Real Estate Taxes			26,400	26,400		26,400		26,400			33
34	Rent-Facility & Grounds							295	295			34
35	Rent-Equipment & Vehicle:			4,191	4,191		4,191	72	4,263			35
36	Other (specify): ³											36
37	TOTAL Ownership			144,097	144,097		144,097	15,685	159,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:			7,149	7,149		7,149		7,149			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			30,135	30,135		30,135		30,135			42
43	Other (specify): ³ Nonallowable Cost			16,841	16,841		16,841	(16,841)				43
44	TOTAL Special Cost Centers		7,149	46,976	54,125		54,125	(16,841)	37,284			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	750,182	183,770	438,169	1,372,121		1,372,121	31,227	1,403,348			45

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

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,717	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(949)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,140)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(38)	43		24
25	Fund Raising, Advertising and Promotions	(4,697)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg 5A	(13,335)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,442)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	45,669		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 45,669		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 31,227		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
ALEDO REHAB & HEALTH CARE CENTER

ID# 0047142

Report Period Beginning: 05/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (1,977)	43	1
2	Cable TV	(6,765)	43	2
3	Special Events	(1,275)	43	3
4	Miscellaneous income offset	(826)	21	4
5	Meal income offset	(2,492)	2	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	(13,335)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	See PG7	See Attached Schedule 6A		See Attached Schedule 6A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,793	\$ 1,793	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	57	57	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	41	41	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	273	273	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,353	2,353	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	512	512	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,967	2,967	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	2	2	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	411	411	10
11	V	17 Administrative	20,000	Petersen Health Care, Inc.	100.00%	12,703	(7,297)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,689	3,689	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,679	1,679	13
14	Total		\$ 20,000			\$ 26,483	\$ *	6,483 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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 16,390	\$ 16,390
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	266	266
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	365	365
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,329	1,329
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	485	485
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,646	3,646
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,335	2,335
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,142	3,142
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	295	295
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	72	72
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,000			\$ 54,808	\$ * 34,808

* Total must agree with the amount recorded on line 34 of Schedule V1

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	5 Utilities	\$	Petersen Health Enterprises	0.00%	\$ 23	\$ 23
16	V	19 Professional Services		Petersen Health Enterprises	0.00%	1,264	1,264
17	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises	0.00%	1,650	1,650
18	V	21 Clerical & General Office		Petersen Health Enterprises	0.00%	1,556	1,556
19	V	22 Employee Benefits		Petersen Health Enterprises	0.00%	2,001	2,001
20	V	25 Other Admin. Staff Transport		Petersen Health Enterprises	0.00%	243	243
21	V	32 Interest		Petersen Health Enterprises	0.00%	4,124	4,124
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 10,861	\$ * 10,861

* Total must agree with the amount recorded on line 34 of Schedule V1

Aledo Rehabilitation & Health Care Center
 Provider # 0047142
 12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watska Rehabilitation & Health Care Center	Watska, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENT # 0047142 Report Period Beginning: 05/01/2005 Ending: 12/31/2005

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	65.00	See Schedule 7A	1	2.00	Salary	\$ 12,703	L17,C7	1
2	Jifi Jacob	Owner	Owner	10.00	73,822	1	1.50	Salary	1,611	L17, C7	2
3	Cindy White	Owner	Owner	10.00	117,501	1	1.50	Salary	0	N/A	3
4	Jacque Whitley	Owner	Owner	10.00	107,813	1	1.50	Salary	0	N/A	4
5	Amrit Jacob	Administrator	Administrative	0.00	32,289	N/A	N/A	Salary	0	N/A	5
6	David Petersen	Owner	Owner	5.00	0	N/A	N/A	N/A	0	N/A	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,314		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER # 0047142 Report Period Beginning: 05/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Patient Days	683,169	46	\$ 82,166	\$ 81,693	14,911	\$ 1,793	1
2	2 Food	Patient Days	683,169	46	2,606		14,911	57	2
3	3 Housekeeping	Patient Days	683,169	46	1,857		14,911	41	3
4	4 Laundry	Patient Days	683,169	46	144		14,911	3	4
5	5 Utilities	Patient Days	683,169	46	12,513		14,911	273	5
6	6 Maintenance	Patient Days	683,169	46	107,775	81,080	14,911	2,353	6
7	7 Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		14,911	512	7
8	10 Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	14,911	2,967	8
9	10A Therapy	Patient Days	683,169	46	88		14,911	2	9
10	15 Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		14,911	411	10
11	17 Administrative	Patient Days	683,169	46	582,000	582,000	14,911	12,703	11
12	19 Professional Services	Patient Days	683,169	46	168,984		14,911	3,689	12
13	20 Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		14,911	1,679	13
14	21 Clerical & General Office	Patient Days	683,169	46	750,958	577,218	14,911	16,390	14
15	23 Inservice Training & Education	Patient Days	683,169	46	12,208		14,911	266	15
16	24 Travel & Seminar	Patient Days	683,169	46	16,731		14,911	365	16
17	25 Other Admin. Staff Transport	Patient Days	683,169	46	60,875		14,911	1,329	17
18	26 Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		14,911	485	18
19	27 Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		14,911	3,646	19
20	30 Depreciation	Patient Days	683,169	46	106,965		14,911	2,335	20
21	32 Interest	Patient Days	683,169	46	143,934		14,911	3,142	21
22	34 Rent - Facility & Grounds	Patient Days	683,169	46	13,500		14,911	295	22
23	35 Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		14,911	72	23
24									24
25	TOTALS				\$ 2,511,007	\$ 1,452,642		\$ 54,808	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER # 0047142 Report Period Beginning: 05/01/2005 Ending: 2/31/2005

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 Enterprises
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	54,205	4	\$ 85	\$ 14,911	\$ 23	1
2	19	Professional Services	Patient Days	54,205	4	4,595	14,911	1,264	2
3	20	Dues, Fees, Subs & Promos	Patient Days	54,205	4	5,997	14,911	1,650	3
4	21	Clerical & General Office	Patient Days	54,205	4	5,657	14,911	1,556	4
5	22	Employee Benefits	Patient Days	54,205	4	7,273	14,911	2,001	5
6	25	Other Admin. Staff Transport	Patient Days	54,205	4	883	14,911	243	6
7	32	Interest	Patient Days	54,205	4	14,991	14,911	4,124	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	TOTALS					\$ 39,481	\$	\$ 10,861	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ALEDO REHAB & HEALTH CARE CENTI** # **0047142** Report Period Beginning: **05/01/2005** Ending: **12/31/2005**

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	F & M Bank of Galesburg		X	Mortgage	Varies	5/6/2005	\$ 2,810,000	\$ 1,241,185	5/6/2008	0.0748	\$ 61,947	1
2	Georgia Commercial Mgmt, Inc		X	Second Mortgage	\$3,041.00	5/1/2005	150,000	135,421	5/1/2007	0.0800	6,711	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$3,041.00		\$ 2,960,000	\$ 1,376,606			\$ 68,658	9
	B. Non-Facility Related*											
10												10
11									Allocated from home office		7,266	11
12									Amortization of mortgage costs		8,480	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 15,746	14
15	TOTALS (line 9+line14)						\$ 2,960,000	\$ 1,376,606			\$ 84,404	15

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 29,623	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.)	2004	\$ 23,278	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,345)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 32,745	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		\$ 26,400	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000		8
	2001	19,767	9
	2002	20,746	10
	2003	21,400	11
	2004	23,278	12
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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 filec

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALEDO REHAB & HEALTH CARE CENTER COUNTY MERCER

FACILITY IDPH LICENSE NUMBER 0047142

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 2004 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 2004.

(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>10-10-20-302-002</u>	<u>Long Term Care Facility</u>	\$ <u>23,278.00</u>	\$ <u>23,278.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,278.00</u>	\$ <u>23,278.00</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER

0047142 Report Period Beginning:

05/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,378 B. General Construction Type: Exterior Brick Frame Block 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et 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	Patient Care	27,378	2005	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ALEDO REHAB & HEALTH CARE CENTER**

0047142

Report Period Beginning:

05/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	80	2005	1973	\$ 1,021,600	\$ 21,283	30	\$ 22,702	\$ 1,419	\$ 22,702
5									
6	Allocated from Home Office	2005		14,859			279	279	279
7									
8									
Improvement Type**									
9	Nurse Call CE & Hardware		2005	2,698	270	5	360	90	360
10	Company Sign		2005	2,537	127	10	127		127
11	Carpet		2005	1,681	84	10	14	(70)	14
12									
13									
14									
15									
16									
17									
18									
19									
20	2005 - Home Office Allocation - Land Improvements		2005	859			27	27	27
21	2005 - Home Office Allocation - Building Improvements		2005	24			1	1	1
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		\$ 1,044,258	\$ 21,764		\$ 23,510	\$ 1,746	\$ 23,510	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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 instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	289,665	14,604	18,882	4,278	5-10 yrs	18,882	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			2,028	2,028			74
75	TOTALS	\$ 289,665	\$ 14,604	\$ 20,910	\$ 6,306		\$ 18,882	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Asset

	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)	\$ 1,383,923	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,368	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,420	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,052	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 42,392	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Home office allocation				295			6
7	TOTAL				\$ 295			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

Fiscal Year Ending Annual Rent

12. /2006 \$ _____
 13. /2007 \$ _____
 14. /2008 \$ _____

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: \$ 4,263 Description: See attached Schedule 14A
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Aledo Rehabilitation & Health Care Center
Provider # 0047142
12/31/2005

Schedule 14A

B. 16 - Rental Amount for Movable Equipment

Oxygen Concentrator	800
Oxygen Tank	129
Dish Machine	438
Laundry Equipment	985
Floor Stripper	25
Copy Machine	1,814
Allocated from Home Office	72
	<u>4,263</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
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 benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	223	\$ 14,486					223	\$ 14,486	1	
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		80	5,184					80	5,184	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	L10, C2, C3	hrs		207	13,466			615		207	14,081	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	L39, C2	# of prescripts						6,859			6,859	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): Oxygen	L39, C2							290			290	13	
14	TOTAL			\$	510	\$ 33,136			\$ 7,764		510	\$ 40,900	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER

0047142

Report Period Beginning: 05/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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	\$ 42,495	\$ 42,495	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	345,609	345,609	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,428	8,428	6
7	Other Prepaid Expenses	10,943	10,943	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 407,475	\$ 407,475	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000	50,000	13
14	Buildings, at Historical Cost	1,021,600	1,036,459	14
15	Leasehold Improvements, at Historical Cost	6,916	7,799	15
16	Equipment, at Historical Cost	289,665	289,665	16
17	Accumulated Depreciation (book methods)	(36,368)	(42,392)	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 (sp. See Schedule 17A)	29,610	29,610	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,361,423	\$ 1,371,141	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,768,898	\$ 1,778,616	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 140,522	\$ 140,522	26
27	Officer's Accounts Payable	3,941	3,941	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,475	35,475	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,311	14,311	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,745	32,745	32
33	Accrued Interest Payable	3,818	3,818	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify): _____			36
37	Accrued Expenses	5,041	5,041	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 235,853	\$ 235,853	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,376,606	1,376,606	40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify): _____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,376,606	\$ 1,376,606	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,612,459	\$ 1,612,459	46
47	TOTAL EQUITY(page 18, line 24)	\$ 156,439	\$ 166,157	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,768,898	\$ 1,778,616	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

ALEDO REHAB & HEALTH CARE CENTER

Provider #: 0047142

05/01/2005 to 12/31/2005

Schedule 17A

XV. Balance Sheet. SUPPORT SCHEDULE

	<u>Operating</u>	<u>After Consolidation</u>
Line 22 - Other Long-Term Assets		
Loan Costs	38,090	38,090
Loan Costs Accumulated Amortization	(8,480)	(8,480)
	<u>29,610</u>	<u>29,610</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	156,439	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)	\$ 156,439	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)	\$ 156,439	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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 expenses

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Car	\$ 1,386,510	1
2	Discounts and Allowances for all Level	3,529	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,390,039	3
B. Ancillary Revenue			
4	Day Care	53	4
5	Other Care for Outpatients		5
6	Therapy	100,256	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 100,309	8
C. Other Operating Revenue			
9	Payments for Educator		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	2,492	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,838	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,056	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,386	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	826	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 826	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,528,560	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	362,634	31
32	Health Care	616,204	32
33	General Administrator	195,061	33
B. Capital Expense			
34	Ownership	144,097	34
C. Ancillary Expense			
35	Special Cost Centers	23,990	35
36	Provider Participation Fee	30,135	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,372,121	40
41	Income before Income Taxes (line 30 minus line 40)**	156,439	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 156,439	43

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

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

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

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

Facility Name & ID Number **ALEDO REHAB & HEALTH CARE CENTER**

0047142

Report Period Beginning: 05/01/2005

Ending:

12/31/2005

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	1,347	1,347	\$ 27,734	\$ 20.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,571	2,571	45,252	17.60	3
4	Licensed Practical Nurses	7,882	7,882	102,822	13.05	4
5	CNAs & Orderlies	29,815	29,815	272,416	9.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,526	1,526	15,047	9.86	8
9	Activity Director	542	542	4,658	8.59	9
10	Activity Assistants	3,125	3,125	26,834	8.59	10
11	Social Service Worker	2,822	2,822	20,839	7.38	11
12	Dietician					12
13	Food Service Supervisor	1,449	1,449	10,297	7.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,311	8,311	59,061	7.11	15
16	Dishwashers					16
17	Maintenance Worker	2,135	2,135	17,326	8.12	17
18	Housekeepers	7,899	7,899	57,606	7.29	18
19	Laundry	3,401	3,401	28,963	8.52	19
20	Administrator	1,327	1,327	29,404	22.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	569	569	5,278	9.28	24
25	Vocational Instructor					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,343	1,343	10,351	7.71	31
32	Other Health C: Care Plan Coordin	1,428	1,428	16,294	11.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	77,492	77,492	\$ 750,182 *	\$ 9.68	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	24 hrs	\$ 901	L1, C3	35
36	Medical Director	8 visits	4,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6 visits	480	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) <u>Rehab Consultant</u>	3 hrs	103	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 5,484		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Shaile Hart	Administrator	0	\$ 24,405	Workers' Compensation Insurance	\$ 19,532	IDPH License Fee	\$	
Jim Steenberg	Administrator	0	4,999	Unemployment Compensation Insurance	17,600	Advertising: Employee Recruitment	1,289	
				FICA Taxes	52,754	Health Care Worker Background Check		
				Employee Health Insurance	3,763	(Indicate # of checks performed <u>50</u>)	590	
				Employee Meals	1,682	Licenses & Permits	1,095	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	231	
				Employee Life Insurance	71			
				Employee Relations	837			
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated from Home Office	3,329	
(List each licensed administrator separately.)			\$ 29,404					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount	Allocated from Home Office	2,001	Non-allowable advertising	()	
Management Fees (eliminated in Column 7)			\$ 20,000			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 20,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 98,240	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,534	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
LTC Solutions	Computer Services		\$ 1,850				Out-of-State Travel	\$
Farnsworth Group	Architect		1,701	N/A				
							In-State Travel	131
							Seminar Expense	120
							Allocated from Home Office	365
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,551				TOTAL	\$ 616

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Aledo Rehabilitation & Health Care Center
Provider # 0047142
12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 3,551

Allocated from Home Office

Legal 70

Other 4,883 4,953

Total (agree to Schedule V, line 19, column 8) 8,504

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	13 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALEDO REHAB & HEALTH CARE CENTER# 0047142Report Period Beginning: 05/01/2005 Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount: N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 1,621 Line 10,2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO 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. \$ 30,135
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 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 if 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. \$ 1,682 Has any meal income been offset against related costs? Yes Indicate the amount \$ 2,492
- (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 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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

09:53 AM 5/16/2006

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 Detail	31,227	equal to	31,227	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	84,404	equal to	84,404	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	26,400	equal to	26,400	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	44,420	equal to	44,420	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	295	equal to	295	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	4,263	equal to	4,263	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	33,751	equal to	33,751	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	7,764	equal to	7,764	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	362,634	equal to	362,634	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	616,204	equal to	616,204	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	195,061	equal to	195,061	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	144,097	equal to	144,097	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	23,990	equal to	23,990	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	30,135	equal to	30,135	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	489,916	equal to	489,916	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	31,492	equal to	31,492	0	O.K.	Pg20 K19+K20	A.	9-10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,839	equal to	20,839	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	69,358	equal to	69,358	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	17,326	equal to	17,326	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	57,606	equal to	57,606	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	28,963	equal to	28,963	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	29,404	equal to	29,404	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	5,278	equal to	5,278	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	750,182	equal to	750,182	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	901	< or = to	901	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,000	< or = to	4,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	583	< or = to	583	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	2,673	-2,673	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	29,404	equal to	29,404	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	20,000	equal to	20,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	3,551	equal to	3,551	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	98,240	equal to	98,240	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,534	equal to	6,534	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	616	equal to	616	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	30,135	equal to	30,135	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,682	< or = to	3,683	-2,001	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,682	equal to	1,682	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	698	equal to	698	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	45,669	equal to	45,669	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	1,376,606	equal to	1,376,606	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	32,745	equal to	32,745	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,044,258	equal to	1,044,258	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	289,665	equal to	289,665	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	42,392	equal to	42,392	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	156,439	equal to	156,439	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	156,439	equal to	156,439	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,768,898	equal to	1,768,898	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

ALEDO REHAB & HEALTH CARE CENTER
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/05

Enter your HSA # in next column = 10
 Census (Pulls from Page 2) 14,911

Cost Report Line	Description	Average Median Cost Per Day (2003)		
		Your Facility	State	HSA
1	Dietary	5.46	6.01	7.02
2	Food Purchase	4.75	4.31	4.47
3	Housekeeping	4.74	3.70	3.59
4	Laundry	2.68	1.85	2.23
5	Heat & Other Utilities	2.72	2.95	3.17
6	Maintenance	3.99	3.01	3.26
8	Total General Services	24.38	22.58	24.49
10	Nursing & Medical Records	35.21	41.83	42.52
10A	Therapy	2.26	2.10	1.86
11	Activities	2.36	1.91	2.18
12	Social Services	1.43	1.42	1.45
16	Total Health Care & Programs	41.55	49.48	50.39
17	Administration	2.82	3.36	3.33
19	Professional Services	0.57	0.99	1.09
21	Clerical & Gen. Office Expense	2.36	4.79	4.32
22	Employee Benefits & PR Taxes	6.59	10.09	10.42
24	Travel & Seminar	0.04	0.08	0.10
26	Insurance-Property, Liability & Malpractice	1.44	2.58	2.47
28	Total General Administrative	14.97	24.94	25.31
29	Total Operating Expenses	80.90	98.06	100.77
30	Depreciation	2.98	3.70	3.82
32	Interest	5.66	2.54	2.81
33	Real Estate Taxes	1.77	1.38	0.92
37	Total Ownership and Ownership Cost	91.61	109.17	110.50

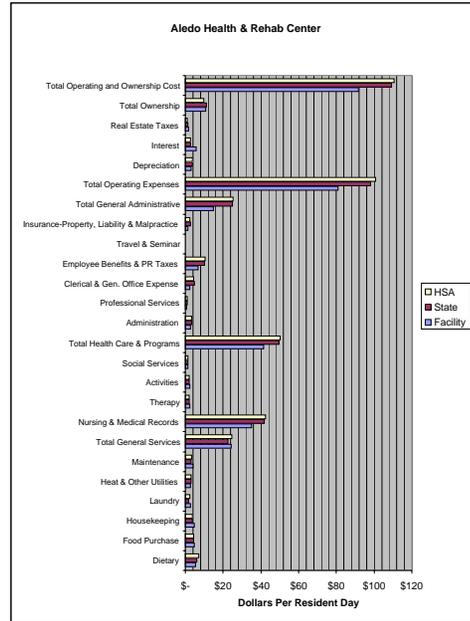
IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Cost Report Line	Description	State-Wide	HSA											10th %	90th %
			1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	11.11	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	23.58
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14

Notes:
 Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
 The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	69,358	9,415	901	79,674	0	79,674	1,793	81,467
2. Food Purchase	0	74,959	0	74,959	0	74,959	-4,117	70,842
3. Housekeeping	57,606	12,960	0	70,566	0	70,566	41	70,607
4. Laundry	28,963	10,982	0	39,945	0	39,945	3	39,948
5. Heat and Other Utilities	0	0	40,316	40,316	0	40,316	296	40,612
6. Maintenance	17,326	28,452	11,396	57,174	0	57,174	2,353	59,527
7. Other (specify)*	0	0	0	0	0	0	512	512
8. Total General Services	173,253	136,768	52,613	362,634	0	362,634	881	363,515
9. Medical Director	0	0	4,000	4,000	0	4,000	0	4,000
10. Nursing & Medical Records	489,916	31,494	583	521,993	0	521,993	2,967	524,960
10a. Therapy	0	615	33,136	33,751	0	33,751	2	33,753
11. Activities	31,492	983	2,673	35,148	0	35,148	0	35,148
12. Social Services	20,839	473	0	21,312	0	21,312	0	21,312
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	411	411
16. Total Health Care & Programs	542,247	33,565	40,392	616,204	0	616,204	3,380	619,584
17. Administrative	29,404	0	20,000	49,404	0	49,404	-7,297	42,107
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	3,551	3,551	0	3,551	4,953	8,504
20. Fees, Subscriptions & Promotion	0	0	3,205	3,205	0	3,205	3,329	6,534
21. Clerical & General Office	5,278	6,288	6,491	18,057	0	18,057	17,120	35,177
22. Employee Benefits & Payroll	0	0	94,557	94,557	0	94,557	3,683	98,240
23. Inservice Training & Education	0	0	803	803	0	803	266	1,069
24. Travel and Seminar	0	0	251	251	0	251	365	616
25. Other Admin. Staff Trans	0	0	4,242	4,242	0	4,242	1,572	5,814
26. Insurance-Prop.Liab.Malpractice	0	0	20,991	20,991	0	20,991	485	21,476
27. Other (specify)*	0	0	0	0	0	0	3,646	3,646
28. Total General Adminis	34,682	6,288	154,091	195,061	0	195,061	28,122	223,183
29. Total General Administrative	750,182	176,621	247,096	1,173,899	0	1,173,899	32,383	1,206,282
30. Depreciation	0	0	36,368	36,368	0	36,368	8,052	44,420
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	77,138	77,138	0	77,138	7,266	84,404
33. Real Estate	0	0	26,400	26,400	0	26,400	0	26,400
34. Rent - Facility & Grounds	0	0	0	0	0	0	295	295
35. Rent - Equipment & Vehicles	0	0	4,191	4,191	0	4,191	72	4,263
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	144,097	144,097	0	144,097	15,685	159,782
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	7,149	0	7,149	0	7,149	0	7,149
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	30,135	30,135	0	30,135	0	30,135
43. Other (specify):*	0	0	16,841	16,841	0	16,841	-16,841	0
44. Total Special Cost Ce	0	7,149	46,976	54,125	0	54,125	-16,841	37,284
45. Grand Total	750,182	183,770	438,169	1,372,121	0	1,372,121	31,227	1,403,348

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	42,495	42,495
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	345,609	345,609
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	8,428	8,428
7. Other Prepaid Expenses	10,943	10,943
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	407,475	407,475
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	50,000	50,000
14. Buildings, at Historical Cost	1,021,600	1,036,459
15. Leasehold Improvements, Historical Cost	6,916	7,799
16. Equipment, at Historical Cost	289,665	289,665
17. Accumulated Depreciation (book methods)	-36,368	-42,392
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	29,610	29,610
23. other (specify):	0	0
24. Total Long-Term Assets	1,361,423	1,371,141
25. Total Assets	1,768,898	1,778,616
CURRENT LIABILITIES		
26. Accounts Payable	140,522	140,522
27. Officer's Accounts Payable	3,941	3,941
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	35,475	35,475
31. Accrued Taxes Payable	14,311	14,311
32. Accrued Real Estate Taxes	32,745	32,745
33. Accrued Interest Payable	3,818	3,818
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	5,041	5,041
38. Total Current Liabilities	235,853	235,853
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	1,376,606	1,376,606
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,376,606	1,376,606
46. Total Liabilities	1,612,459	1,612,459
47. Total Equity	156,439	166,157
48. Total Liabilities and Equity	1,768,898	1,778,616

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,386,510
2. Discounts and Allowances for all Levels	3,529
Subtotal - Inpatient Care	1,390,039
4. Day Care	53
5. Other Care for Outpatients	0
6. Therapy	100,256
7. Oxygen	0
Subtotal - Ancillary Revenue	100,309
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	2,492
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	28,838
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	6,056
22. Laundry	0
Subtotal - Other Operating Revenue	37,386
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	826
28. Other Revenue (specify):	0
Subtotal - Other Revenue	826
30. Total Revenue	1,528,560
31. General Services	362,634
32. Health Care	616,204
33. General Administration	195,061
34. Ownership	144,097
35. Special Cost Centers	23,990
35. Provider Participation Fee	30,135
37. Other	0
40. Total Expenses	1,372,121
41. Income Before Income Taxes	156,439
42. Income Taxes	0
43. Net Income or Loss for the Year	156,439