

Facility Name & ID Number Aspen Rehabilitation & Health Care Center

0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	16,176	3,921		20,097
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	16,176	3,921		20,097

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.40%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2005 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	93,668	11,025	1,064	105,757		105,757	1,997	107,754		1
2	Food Purchase		78,926		78,926		78,926	(1,094)	77,832		2
3	Housekeeping	48,443	12,545		60,988		60,988	64	61,052		3
4	Laundry	49,889	6,139		56,028		56,028		56,028		4
5	Heat and Other Utilities			46,560	46,560		46,560	265	46,825		5
6	Maintenance	30,952	18,852	6,980	56,784		56,784	4,950	61,734		6
7	Other (specify):* Home Office Benefits							1,244	1,244		7
8	TOTAL General Services	222,952	127,487	54,604	405,043		405,043	7,426	412,469		8
	B. Health Care and Programs										
9	Medical Director			11,595	11,595		11,595		11,595		9
10	Nursing and Medical Records	718,644	34,308	1,138	754,090		754,090	6,168	760,258		10
10a	Therapy			6,131	6,131		6,131	474	6,605		10a
11	Activities	41,153	542	1,095	42,790		42,790		42,790		11
12	Social Services	40,007			40,007		40,007		40,007		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,940	1,940		15
16	TOTAL Health Care and Programs	799,804	34,850	19,959	854,613		854,613	8,582	863,195		16
	C. General Administration										
17	Administrative	67,691		43,500	111,191		111,191	(28,222)	82,969		17
18	Directors Fees										18
19	Professional Services			1,929	1,929		1,929	8,306	10,235		19
20	Dues, Fees, Subscriptions & Promotions			4,860	4,860		4,860	984	5,844		20
21	Clerical & General Office Expenses	28,552	3,822	5,543	37,917		37,917	26,895	64,812		21
22	Employee Benefits & Payroll Taxes			208,529	208,529		208,529		208,529		22
23	Inservice Training & Education			262	262		262	184	446		23
24	Travel and Seminar			285	285		285	530	815		24
25	Other Admin. Staff Transportation			2,679	2,679		2,679	2,167	4,846		25
26	Insurance-Prop.Liab.Malpractice			19,926	19,926		19,926	1,133	21,059		26
27	Other (specify):* Home Office Benefits							5,529	5,529		27
28	TOTAL General Administration	96,243	3,822	287,513	387,578		387,578	17,506	405,084		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,118,999	166,159	362,076	1,647,234		1,647,234	33,514	1,680,748		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			68,869	68,869		68,869	6,593	75,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,450	116,450		116,450	17,408	133,858			32
33	Real Estate Taxes			42,800	42,800		42,800	1,985	44,785			33
34	Rent-Facility & Grounds							904	904			34
35	Rent-Equipment & Vehicles			18,688	18,688		18,688	590	19,278			35
36	Other (specify):*											36
37	TOTAL Ownership			246,807	246,807		246,807	27,480	274,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Nonallowable Cost			13,985	13,985		13,985	(13,985)				43
44	TOTAL Special Cost Centers			48,478	48,478		48,478	(13,985)	34,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,118,999	166,159	657,361	1,942,519		1,942,519	47,009	1,989,528			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 Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(100)	30		9
10	Interest and Other Investment Income	(3,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(350)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,666)	43		24
25	Fund Raising, Advertising and Promotional	(2,255)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(13,226)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,015)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	73,024	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 73,024		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 47,009		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Aspen Rehabilitation & Health Care Center

ID# 0047381

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (3,565)	43	1
2	Offset meal revenue	(1,168)	2	2
3	Misc Income	(1,586)	21	3
4	Nonallowable Home Office Architect Fees	(446)	19	4
5	Marketing Supplies	(963)	43	5
6	Nonallowable Travel	(5,498)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,226)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aspen Rehabilitation & Health Care Center# 0047381

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,429	0	568	0	0	0	0	0	0	0	1,997	1
2	Food Purchase	(1,168)	70	0	4	0	0	0	0	0	0	0	(1,094)	2
3	Housekeeping	0	63	0	1	0	0	0	0	0	0	0	64	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	265	0	0	0	0	0	0	0	0	0	265	5
6	Maintenance	0	3,634	0	1,316	0	0	0	0	0	0	0	4,950	6
7	Other (specify):*	0	573	0	671	0	0	0	0	0	0	0	1,244	7
8	TOTAL General Services	(1,168)	6,034	0	2,560	0	7,426	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	0	5,167	0	1,001	0	0	0	0	0	0	0	6,168	10
10a	Therapy	0	474	0	0	0	0	0	0	0	0	0	474	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,597	0	343	0	0	0	0	0	0	0	1,940	15
16	TOTAL Health Care and Programs	0	7,238	0	1,344	0	8,582	16						
	C. General Administration													
17	Administrative	0	(29,415)	0	1,193	0	0	0	0	0	0	0	(28,222)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(446)	6,169	0	2,583	0	0	0	0	0	0	0	8,306	19
20	Fees, Subscriptions & Promotions	0	604	0	380	0	0	0	0	0	0	0	984	20
21	Clerical & General Office Expenses	(1,586)	0	22,706	5,775	0	0	0	0	0	0	0	26,895	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	184	0	0	0	0	0	0	0	0	184	23
24	Travel and Seminar	(5,498)	0	5,498	530	0	0	0	0	0	0	0	530	24
25	Other Admin. Staff Transportation	0	0	1,462	705	0	0	0	0	0	0	0	2,167	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,082	51	0	0	0	0	0	0	0	1,133	26
27	Other (specify):*	0	0	4,013	1,516	0	0	0	0	0	0	0	5,529	27
28	TOTAL General Administration	(7,530)	(22,642)	34,945	12,733	0	17,506	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,698)	(9,370)	34,945	16,637	0	33,514	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Capital Expense	PAGES	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	(100)	0	5,598	1,095	0	0	0	0	0	0	0	6,593	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,232)	0	3,110	17,530	0	0	0	0	0	0	0	17,408	32
33	Real Estate Taxes	0	0	656	1,329	0	0	0	0	0	0	0	1,985	33
34	Rent-Facility & Grounds	0	0	636	268	0	0	0	0	0	0	0	904	34
35	Rent-Equipment & Vehicles	0	0	333	257	0	0	0	0	0	0	0	590	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,332)	0	10,333	20,479	0	27,480	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):*	(13,985)	0	0	0	0	0	0	0	0	0	0	(13,985)	43
44	TOTAL Special Cost Centers	(13,985)	0	0	0	0	0	0	0	0	0	0	(13,985)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(26,015)	(9,370)	45,278	37,116	0	47,009	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 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%	\$ 1,429	\$ 1,429	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	70	70	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	63	63	3
								4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	265	265	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,634	3,634	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	573	573	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,167	5,167	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	474	474	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,597	1,597	10
11	V	17 Administrative	43,500	Petersen Health Care, Inc.	100.00%	14,085	(29,415)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,169	6,169	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	604	604	13
14	Total		\$ 43,500			\$ 34,130	\$ * (9,370)	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%	\$ 22,706	\$	22,706	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	184		184	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,498		5,498	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,462		1,462	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,082		1,082	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,013		4,013	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,598		5,598	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,110		3,110	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	656		656	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	636		636	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	333		333	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		\$			\$ 45,278	\$ *	45,278	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 <u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 568	\$	568	15
16	V	2 <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4		4	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1		1	17
18	V								18
19									19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,316		1,316	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	671		671	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,001		1,001	22
23	V	10A <u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	343		343	24
25	V	17 <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,193		1,193	25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,583		2,583	26
27	V	20 <u>Due, Fees, Subs & Promos</u>		<u>Petersen Health Care, Inc.</u>	100.00%	380		380	27
28	V	21 <u>Clerical & General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,775		5,775	28
29									29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	530		530	30
31	V	25 <u>Other Admin. Staff Transport</u>		<u>Petersen Health Care, Inc.</u>	100.00%	705		705	31
32	V	26 <u>Insurance-Prop.Liab.Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	51		51	32
33	V	27 <u>Mgmt Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,516		1,516	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,095		1,095	34
35	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	17,530		17,530	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,329		1,329	36
37	V	34 <u>Rent - Facility & Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	268		268	37
38	V	35 <u>Rent - Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	257		257	38
39	Total		\$			\$ 37,116	\$ *	37,116	39

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

Facility Name & ID Number Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.88	1.76	Salary	\$ 14,085	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,085		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 Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	20,097	\$ 1,429	1
2	2	Food	Patient Days	1,141,463	56	3,989		20,097	70	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		20,097	63	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		20,097	265	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	20,097	3,634	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		20,097	573	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	20,097	5,167	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		20,097	474	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		20,097	1,597	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	20,097	14,085	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	0	20,097	6,169	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		20,097	604	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	20,097	22,706	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		20,097	184	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		20,097	5,498	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		20,097	1,462	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		20,097	1,082	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		20,097	4,013	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		20,097	5,598	20
21	32	Interest	Patient Days	1,141,463	56	176,614		20,097	3,110	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		20,097	656	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		20,097	636	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		20,097	333	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999		\$ 79,408	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	46	\$ 12,081	\$ 11,958	20,097	\$ 568	1
2	2	Food	Patient Days	46	93		20,097	4	2
3	3	Housekeeping	Patient Days	46	28		20,097	1	3
4									4
5									5
6	6	Maintenance	Patient Days	46	28,012	28,012	20,097	1,316	6
7	7	Mgmt. Allocation of Benefits	Patient Days	46	14,282		20,097	671	7
8	10	Nursing and Medical Records	Patient Days	46	21,299	20,434	20,097	1,001	8
9	10A	Therapy	Patient Days	46			20,097		9
10	15	Mgmt. Allocation of Benefits	Patient Days	46	7,301		20,097	343	10
11	17	Administrative	Patient Days	46	25,391	25,391	20,097	1,193	11
12	19	Professional Services	Patient Days	46	54,971		20,097	2,583	12
13	20	Due, Fees, Subs & Promos	Patient Days	46	8,088		20,097	380	13
14	21	Clerical & General Office	Patient Days	46	122,893	64,907	20,097	5,775	14
15									15
16	24	Travel and Seminar	Patient Days	46	11,280		20,097	530	16
17	25	Other Admin. Staff Transport	Patient Days	46	15,003		20,097	705	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	46	1,087		20,097	51	18
19	27	Mgmt Allocation of Benefits	Patient Days	46	32,265		20,097	1,516	19
20	30	Depreciation	Patient Days	46	23,301		20,097	1,095	20
21	32	Interest	Patient Days	46	373,049		20,097	17,530	21
22	33	Real Estate Taxes	Patient Days	46	28,282		20,097	1,329	22
23	34	Rent - Facility & Grounds	Patient Days	46	5,700		20,097	268	23
24	35	Rent - Equipment & Vehicles	Patient Days	46	5,479		20,097	257	24
25	TOTALS				\$ 789,885	\$ 150,702		\$ 37,116	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aspen Rehabilitation & Health Care Center # 0047381 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 1,020,000	\$ 1,005,111	09/20/10	Varies	\$ 86,725	1								
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	190,000	189,652	09/20/10	0.1000	29,725	2								
3												3								
4							Allocated from Home Office				20,640	4								
5							Interest Income Offset				(3,232)	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,210,000	\$ 1,194,763			\$ 133,858	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,210,000	\$ 1,194,763			\$ 133,858	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.)

IMPORTANT NOTICE

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

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

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspen Rehabilitation & Health Care Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047381

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 2005 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 2005.

(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>06-100-14-00</u>	<u>Nursing Home</u>	\$ <u>42,729.76</u>	\$ <u>42,729.76</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,985.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,729.76</u>	\$ <u>44,714.76</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,656 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>261,360</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	261,360		\$ 54,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	63	2005	1970	\$ 959,500	\$	25	\$ 38,380	\$ 38,380	\$ 57,570
5		2005		15,000		15	1,000	1,000	1,500
6	06 Home Office								
7	Allocation	2006		11,986			524	524	524
8									
Improvement Type**									
9	Sidewalks		2006	7,180		15	239	239	239
10	Duct Work		2006	584		20	15	15	15
11	Showers		2006	3,401		20	85	85	85
12	Subflooring		2006	5,450		20	136	136	136
13	Land Improvement Booked				1,359			(1,359)	
14	Building Booked				38,405			(38,405)	
15	Building Improvement Booked				141			(141)	
16									
17									
18	2006 Home Office allocation - Land & Land Improvements		2006	693			64	64	64
19	2006 Home Office allocation - Buildings Improvements		2006	20			1	1	1
20									
21									
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	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70	
			1,003,814		39,905		40,444	539	60,134

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 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	\$ 189,120	\$ 28,964	\$ 28,469	\$ (495)	3-7 Years	\$ 42,703	71
72	Current Year Purchases	4,094		445	445	3-5 Years	445	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			6,104	6,104			74
75	TOTALS	\$ 193,214	\$ 28,964	\$ 35,018	\$ 6,054		\$ 43,148	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,251,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,869	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,462	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,593	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 103,282	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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? YES NO

If NO, see instructions.

		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			904			6
7	TOTAL				\$ 904			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: \$ 19,278 Description: Copier \$3,821; Dishwasher \$826; HO Alloc. \$590; Nursing Equip \$14,041

(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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	35	\$ 2,825	\$	35	\$ 2,825	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3) (7)	hrs		43	3,306	474	43	3,780	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	78	\$ 6,131	\$ 474	78	\$ 6,605	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aspen Rehabilitation & Health Care Center

0047381

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 69,005	\$ 69,005	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	355,343	355,343	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,475	24,475	7
8	Accounts Receivable (owners or related parties)	5,356	5,356	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 454,179	\$ 454,179	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	76,180	54,000	13
14	Buildings, at Historical Cost	968,935	1,003,814	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	193,214	193,214	16
17	Accumulated Depreciation (book methods)	(83,612)	(103,282)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,154,717	\$ 1,147,746	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,608,896	\$ 1,601,925	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,357	\$ 153,357	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,419	21,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,268	6,268	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,800	42,800	32
33	Accrued Interest Payable	12,420	12,420	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	10,528	10,528	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 246,792	\$ 246,792	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	189,652	189,652	40
41	Bonds Payable	1,005,111	1,005,111	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,194,763	\$ 1,194,763	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,441,555	\$ 1,441,555	46
47	TOTAL EQUITY (page 18, line 24)	\$ 167,341	\$ 160,370	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,608,896	\$ 1,601,925	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 69,797	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 69,797	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	97,544	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)	\$ 97,544	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)	\$ 167,341	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 expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,030,566	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,030,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	1,168	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,510	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,678	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,232	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,232	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Rev (offset on P5a)	1,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,040,063	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	405,043	31
32	Health Care	854,613	32
33	General Administration	387,578	33
	B. Capital Expense		
34	Ownership	246,807	34
	C. Ancillary Expense		
35	Special Cost Centers	13,985	35
36	Provider Participation Fee	34,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,942,519	40
41	Income before Income Taxes (line 30 minus line 40)**	97,544	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 97,544	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 Aspen Rehabilitation & Health Care Center

0047381

Report Period Beginning: 01/01/06

Ending: 12/31/06

12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,119	1,223	\$ 34,421	\$ 28.15	1
2	Assistant Director of Nursing	2,064	2,064	35,776	17.33	2
3	Registered Nurses	4,098	4,183	77,484	18.52	3
4	Licensed Practical Nurses	11,038	11,168	185,513	16.61	4
5	CNAs & Orderlies	34,594	35,149	339,553	9.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	1,992	29,373	14.75	9
10	Activity Assistants	1,209	1,217	11,780	9.68	10
11	Social Service Workers	2,080	2,080	40,007	19.23	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,697	13.80	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	9,182	9,220	64,971	7.05	15
16	Dishwashers					16
17	Maintenance Workers	2,102	2,102	30,952	14.73	17
18	Housekeepers	7,176	7,202	48,443	6.73	18
19	Laundry	5,461	5,596	49,889	8.92	19
20	Administrator	1,984	1,984	67,691	34.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,008	2,040	28,552	14.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,064	2,064	45,898	22.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,195	91,364	\$ 1,118,999 *	\$ 12.25	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	23	\$ 1,064	1,3	35
36	Medical Director	Monthly	11,595	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,137	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	23	\$ 13,796		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Petersen Health Care, Inc. (Aspen)
Provider Number - 0047381
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

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

1,929

Allocated from Home Office

Other Professional Fees

6,087

Legal

82

Other Professional Fees - PHO

2,060

Legal - PHO

77

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

10,235

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$								
2																				
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 Aspen Rehabilitation & Health Care Center

0047381

Report Period Beginning:

01/01/06

Ending:

12/31/06

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? 3-5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,763 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,493
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,168
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees