

Facility Name & ID Number Aledo Rehab & Health Care Ctr

0047142 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	29,200	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	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,781	6,642	913	19,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,781	6,642	913	19,336	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.22%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 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 80 and days of care provided 913

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

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

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr # 0047142 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	102,783	14,089		116,872		116,872	1,618	118,490		1
2	Food Purchase		110,742		110,742		110,742	(1,506)	109,236		2
3	Housekeeping	68,794	30,950		99,744		99,744	18	99,762		3
4	Laundry	47,429	22,598		70,027		70,027	1	70,028		4
5	Heat and Other Utilities			80,594	80,594		80,594	276	80,870		5
6	Maintenance	30,589	13,200	29,424	73,213		73,213	2,254	75,467		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							738	738		7
8	TOTAL General Services	249,595	191,579	110,018	551,192		551,192	3,399	554,591		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	696,370	42,916	155,984	895,270		895,270	4,278	899,548		10
10a	Therapy	23,209	308	135,832	159,349		159,349		159,349		10a
11	Activities	51,016	1,327	2,270	54,613		54,613		54,613		11
12	Social Services	47,363			47,363		47,363		47,363		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							951	951		15
16	TOTAL Health Care and Programs	817,958	44,551	299,586	1,162,095		1,162,095	5,229	1,167,324		16
	C. General Administration										
17	Administrative	48,041		77,500	125,541		125,541	(65,455)	60,086		17
18	Directors Fees										18
19	Professional Services			8,241	8,241		8,241	5,025	13,266		19
20	Dues, Fees, Subscriptions & Promotions			9,825	9,825		9,825	734	10,559		20
21	Clerical & General Office Expenses		7,065	8,133	15,198		15,198	27,556	42,754		21
22	Employee Benefits & Payroll Taxes			128,042	128,042		128,042	10,611	138,653		22
23	Inservice Training & Education			110	110		110	382	492		23
24	Travel and Seminar							502	502		24
25	Other Admin. Staff Transportation			8,840	8,840		8,840	1,819	10,659		25
26	Insurance-Prop.Liab.Malpractice			14,171	14,171		14,171	1,389	15,560		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,842	7,842		27
28	TOTAL General Administration	48,041	7,065	254,862	309,968		309,968	(9,595)	300,373		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,115,594	243,195	664,466	2,023,255		2,023,255	(967)	2,022,288		29

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

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

Facility Name & ID Number

Aledo Rehab & Health Care Ctr

#0047142

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			67,456	67,456		67,456	1,601	69,057			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,725	105,725		105,725	10,070	115,795			32
33	Real Estate Taxes			28,508	28,508		28,508	633	29,141			33
34	Rent-Facility & Grounds							39	39			34
35	Rent-Equipment & Vehicles			19,709	19,709		19,709	510	20,219			35
36	Other (specify):*											36
37	TOTAL Ownership			221,398	221,398		221,398	12,853	234,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,762		17,762		17,762		17,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,612	42,612		42,612		42,612			42
43	Other (specify):* Non-allowable Cost		1,138	39,964	41,102		41,102	(41,102)				43
44	TOTAL Special Cost Centers		18,900	82,576	101,476		101,476	(41,102)	60,374			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,115,594	262,095	968,440	2,346,129		2,346,129	(29,216)	2,316,913			45

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

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,562)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,525)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(320)	30		9
10	Interest and Other Investment Income	(1,087)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(489)	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	(885)	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	(22,569)	43		24
25	Fund Raising, Advertising and Promotional	(7,328)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(5,950)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,715)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	17,499	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,499		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (29,216)		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

Aledo Rehab & Health Care Ctr

ID# 0047142

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (476)	43	1
2	X-Rays-Part A	(234)	43	2
3	Resident Flowers	(431)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(2,644)	21	4
5	Disallowed Special Events	(2,165)	20	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	(5,950)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,618	0	0	0	0	0	0	0	0	0	1,618	1
2	Food Purchase	(1,562)	56	0	0	0	0	0	0	0	0	0	(1,506)	2
3	Housekeeping	0	18	0	0	0	0	0	0	0	0	0	18	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	276	0	0	0	0	0	0	0	0	0	276	5
6	Maintenance	0	2,254	0	0	0	0	0	0	0	0	0	2,254	6
7	Other (specify):*	0	738	0	0	0	0	0	0	0	0	0	738	7
8	TOTAL General Services	(1,562)	4,961	0	0	0	0	0	0	0	0	0	3,399	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	4,278	0	0	0	0	0	0	0	0	0	4,278	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	951	0	0	0	0	0	0	0	0	0	951	15
16	TOTAL Health Care and Programs	0	5,229	0	0	0	0	0	0	0	0	0	5,229	16
	C. General Administration													
17	Administrative	0	(65,455)	0	0	0	0	0	0	0	0	0	(65,455)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,270	0	1,755	0	0	0	0	0	0	0	5,025	19
20	Fees, Subscriptions & Promotions	(2,165)	0	709	25	0	0	0	0	0	0	0	(1,431)	20
21	Clerical & General Office Expenses	(2,644)	0	27,427	2,773	0	0	0	0	0	0	0	27,556	21
22	Employee Benefits & Payroll Taxes	0	0	0	10,611	0	0	0	0	0	0	0	10,611	22
23	Inservice Training & Education	0	0	315	67	0	0	0	0	0	0	0	382	23
24	Travel and Seminar	0	0	502	0	0	0	0	0	0	0	0	502	24
25	Other Admin. Staff Transportation	0	0	1,819	0	0	0	0	0	0	0	0	1,819	25
26	Insurance-Prop.Liab.Malpractice	0	0	741	648	0	0	0	0	0	0	0	1,389	26
27	Other (specify):*	0	0	7,842	0	0	0	0	0	0	0	0	7,842	27
28	TOTAL General Administration	(4,809)	(62,185)	39,355	15,879	0	(11,760)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,371)	(51,995)	39,355	15,879	0	(3,132)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(320)	0	1,921	0	0	0	0	0	0	0	0	1,601	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,087)	0	3,338	7,819	0	0	0	0	0	0	0	10,070	32
33	Real Estate Taxes	0	0	633	0	0	0	0	0	0	0	0	633	33
34	Rent-Facility & Grounds	0	0	39	0	0	0	0	0	0	0	0	39	34
35	Rent-Equipment & Vehicles	0	0	510	0	0	0	0	0	0	0	0	510	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,407)	0	6,441	7,819	0	12,853	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):*	(38,937)	0	0	0	0	0	0	0	0	0	0	(38,937)	43
44	TOTAL Special Cost Centers	(38,937)	0	0	0	0	0	0	0	0	0	0	(38,937)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(46,715)	(51,995)	45,796	23,698	0	(29,216)	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	70	See Attached Schedule 6E		See Attached Sch 6E		
Jifi C. Jacob	10	See Attached Schedule 6E		See Attached Sch 6E		
Cindy S. White	10	See Attached Schedule 6E		See Attached Sch 6E		
Jacque Whitley	10	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,618	\$ 1,618	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	56	56	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	276	276	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,254	2,254	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	738	738	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,278	4,278	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	951	951	10
11	V	17 Administrative	77,500	Petersen Health Care, Inc.	100.00%	12,045	(65,455)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,270	3,270	12
13	V							13
14	Total		\$ 77,500			\$ 25,505	\$ * (51,995)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 709	\$	709	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	27,427		27,427	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	315		315	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	502		502	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,819		1,819	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	741		741	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,842		7,842	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,921		1,921	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,338		3,338	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	633		633	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	39		39	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	510		510	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		\$			\$ 45,796	\$ *	45,796	39

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Enterprises, LLC</u>	100.00%	\$ 0	\$ 0
16	V	2 <u>Food</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
18	V	4 <u>Laundry</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
19	V	5 <u>Utilities</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
20	V	6 <u>Maintenance</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
23	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
24	V	17 <u>Administrative</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
25	V	19 <u>Professional Services</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	1,755	1,755
26	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	25	25
27	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	2,773	2,773
28	V	22 <u>Employee Benefits & Payroll</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	10,611	10,611
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	67	67
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	648	648
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
34	V	30 <u>Depreciation</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
35	V	32 <u>Interest</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	7,819	7,819
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0	0
39	Total		\$			\$ 23,698	\$ * 23,698

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr # 0047142 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	70.00	See Schedule 7A	0.79	1.44	Salary	\$ 12,045	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7A	0.81	1.47	Salary	795	L21, C7	2
3	Cindy S. White	Owner	Administrative	10.00	See Schedule 7A	0.81	1.47	Salary	1,983	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7A	0.81	1.47	Salary	1,608	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,431		13

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

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	19,336	\$ 1,618	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	19,336	56	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	19,336	18	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	19,336	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	19,336	276	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	19,336	2,254	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	19,336	738	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	19,336	4,278	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	19,336	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	19,336	951	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	19,336	12,045	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	19,336	3,270	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	19,336	709	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	19,336	27,427	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	19,336	315	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	19,336	502	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	19,336	1,819	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	19,336	741	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	19,336	7,842	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	19,336	1,921	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	19,336	3,338	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	19,336	633	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	19,336	39	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	19,336	510	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 71,301	25

Facility Name & ID Number Aledo Rehab & Health Care Ctr

0047142 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	86,155	5	\$	19,336	\$	1
2	2	Food	Resident Days	86,155	5		19,336		2
3	3	Housekeeping	Resident Days	86,155	5		19,336		3
4	4	Laundry	Resident Days	86,155	5		19,336		4
5	5	Utilities	Resident Days	86,155	5		19,336		5
6	6	Maintenance	Resident Days	86,155	5		19,336		6
7	7	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,336		7
8	10	Nursing and Medical Records	Resident Days	86,155	5		19,336		8
9	15	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,336		9
10	17	Administrative	Resident Days	86,155	5		19,336		10
11	19	Professional Services	Resident Days	86,155	5	7,818	19,336	1,755	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	86,155	5	110	19,336	25	12
13	21	Clerical and General Office	Resident Days	86,155	5	12,357	19,336	2,773	13
14	22	Employee Benefits & Payroll	Resident Days	86,155	5	47,280	19,336	10,611	14
15	23	Inservice Training & Education	Resident Days	86,155	5	300	19,336	67	15
16	24	Travel and Seminar	Resident Days	86,155	5		19,336		16
17	25	Other Admin. Staff Transport.	Resident Days	86,155	5		19,336		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	86,155	5	2,889	19,336	648	18
19	27	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,336		19
20	30	Depreciation	Resident Days	86,155	5		19,336		20
21	32	Interest	Resident Days	86,155	5	34,841	19,336	7,819	21
22	33	Real Estate Taxes	Resident Days	86,155	5		19,336		22
23	34	Rent-Facility and Grounds	Resident Days	86,155	5		19,336		23
24	35	Rent-Equipment & Vehicles	Resident Days	86,155	5		19,336		24
25	TOTALS					\$ 105,595	\$	\$ 23,698	25

Facility Name & ID Number

Aledo Rehab & Health Care Ctr

0047142

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	F&M Bank of Galesburg		X	Mortgage	\$10,166.00	5/6/2005	\$ 1,253,260	\$ 1,180,463	5/6/2008	0.0748	\$ 89,518	1								
2	Georgia Commercial Mgmt. Inc.		X	Second Mortgage	\$3,041.00	5/1/2005	150,000		Paid	0.0800	3,487	2								
3							Interest Income Offset				(1,087)	3								
4							Home Office Allocation-PHC				3,338	4								
5							Home Office Allocation-PHE				7,819	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$13,207.00		\$ 1,403,260	\$ 1,180,463			\$ 103,075	9								
B. Non-Facility Related*																				
10												10								
11							Amortization of Mortgage Costs				12,720	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 12,720	14								
15	TOTALS (line 9+line14)						\$ 1,403,260	\$ 1,180,463			\$ 115,795	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	24,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	25,608	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,508	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	27,000	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. Home Office Allocation			633	
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 6.		\$	29,141	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	22,534	8
	2003	24,341	9
	2004	27,991	10
	2005	24,033	11
	2006	25,608	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aledo Rehab & Health Care Ctr 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>10-10-20-302-002</u>	<u>Long-Term Care Facility</u>	\$ <u>25,608.00</u>	\$ <u>25,608.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>25,608.00</u>	\$ <u>25,608.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr

0047142

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>103,237</u>	<u>1998</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	103,237		\$ 50,000	3

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	80	2005	1973	\$ 1,021,600	\$	30	\$ 34,053	\$ 34,053	\$ 90,808	4
5										5
6										6
7	Home Office Allocation			10,780			263	263		7
8										8
Improvement Type**										
9	Nurse Call CE & Hardware		2005	2,698		5	540	540	1,440	9
10	Company Sign		2005	2,537		10	254	254	635	10
11	Carpet		2005	1,681		10	168	168	350	11
12	Sidewalks		2006	9,946		20	497	497	746	12
13	Sidewalks		2006	20,675		20	1,034	1,034	1,551	13
14	Boiler System		2007	16,250		15	542	542	542	14
15	Alarm System		2007	1,003		10	50	50	50	15
16										16
17										17
18										18
19										19
20										20
21										21
22	Building Booked				34,054			(34,054)		22
23	Building Improvement Booked				5,269			(5,269)		23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			721			43	43		31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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)	\$ 1,087,891	\$ 39,323		\$ 37,444	\$ (1,879)	\$ 96,122	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 278,728	\$ 29,967	\$ 29,739	\$ (228)	5-10 Yrs	\$ 77,829	71
72	Current Year Purchases	5,176	333	259	(74)	10	259	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,615	1,615			74
75	TOTALS	\$ 283,904	\$ 30,300	\$ 31,613	\$ 1,313		\$ 78,088	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,421,795	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,623	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,057	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (566)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 174,210	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>39</u>			6
7	TOTAL				\$ <u>39</u>			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 20,219 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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

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

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

Aledo Rehab & Health Care Ctr
0047142
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 14,784
Dishwasher	1,283
Laundry Equipment	935
Copier	2,707
Home Office Allocation	510
	<u>20,219</u>

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.

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	\$	3,467	\$ 52,001	\$	3,467	\$ 52,001	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		346	5,195		346	5,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,242	78,636	308	5,242	78,944	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				17,762		17,762	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			\$	9,055	\$ 135,832	\$ 18,070	9,055	\$ 153,902	14

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

Facility Name & ID Number Aledo Rehab & Health Care Ctr

0047142

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (140,156)	\$ (140,156)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	337,784	337,784	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,762	12,762	6
7	Other Prepaid Expenses	14,039	14,039	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 224,429	\$ 224,429	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,621	50,000	13
14	Buildings, at Historical Cost	1,021,600	1,032,380	14
15	Leasehold Improvements, at Historical Cost	24,169	55,511	15
16	Equipment, at Historical Cost	283,904	283,904	16
17	Accumulated Depreciation (book methods)	(169,408)	(174,210)	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 (spec <u>Loan Costs</u>)	4,170	4,170	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,245,056	\$ 1,251,755	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,469,485	\$ 1,476,184	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 313,811	\$ 313,811	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,467	76,467	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,399	2,399	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,000	27,000	32
33	Accrued Interest Payable	4,546	4,546	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	15,359	15,359	36
37	<u>Deferred Revenue</u>	14,329	14,329	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 453,911	\$ 453,911	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,180,463	1,180,463	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,180,463	\$ 1,180,463	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,634,374	\$ 1,634,374	46
47	TOTAL EQUITY(page 18, line 24)	\$ (164,889)	\$ (158,190)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,469,485	\$ 1,476,184	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,033	1
2	Restatements (describe):		2
3	<u>Rounding</u>	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,039	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(171,928)	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)	\$ (171,928)	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)	\$ (164,889)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 1,854,862	1
2	Discounts and Allowances for all Levels	86,169	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,941,031	3
	B. Ancillary Revenue		
4	Day Care	272	4
5	Other Care for Outpatients		5
6	Therapy	183,073	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 183,345	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	1,562	14
15	Telephone, Television and Radio	483	15
16	Rental of Facility Space		16
17	Sale of Drugs	36,019	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,782	20
21	Other Medical Services	3,248	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46,094	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,087	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,087	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	2,644	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,644	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,174,201	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	551,192	31
32	Health Care	1,162,095	32
33	General Administration	309,968	33
	B. Capital Expense		
34	Ownership	221,398	34
	C. Ancillary Expense		
35	Special Cost Centers	58,864	35
36	Provider Participation Fee	42,612	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,346,129	40
41	Income before Income Taxes (line 30 minus line 40)**	(171,928)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (171,928)	43

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

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

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

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

Facility Name & ID Number **Aledo Rehab & Health Care Ctr**

0047142

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

Ending: **12/31/2007**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 55,000	\$ 26.44	1
2	Assistant Director of Nursing	1,579	1,579	29,749	18.84	2
3	Registered Nurses	3,491	3,755	79,282	21.11	3
4	Licensed Practical Nurses	11,833	12,240	192,140	15.70	4
5	CNAs & Orderlies	28,726	29,773	306,797	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,961	2,146	23,209	10.82	8
9	Activity Director	1,843	1,843	22,240	12.07	9
10	Activity Assistants	3,759	3,850	28,776	7.47	10
11	Social Service Workers	3,915	4,058	47,363	11.67	11
12	Dietician					12
13	Food Service Supervisor	1,597	1,597	14,956	9.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,756	11,210	87,827	7.83	15
16	Dishwashers					16
17	Maintenance Workers	2,157	2,221	30,589	13.77	17
18	Housekeepers	8,986	9,153	68,794	7.52	18
19	Laundry	6,170	6,323	47,429	7.50	19
20	Administrator	2,080	2,080	48,041	23.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,848	2,022	18,553	9.18	31
32	Other Health C: Care Plan Coord.	260	260	4,940	19.00	32
33	Other(specify) <u>Alz. Coord.</u>	824	824	9,909	12.03	33
34	TOTAL (lines 1 - 33)	93,865	97,014	\$ 1,115,594 *	\$ 11.50	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 5,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,040	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)	\$ 6,540		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	2,993 125,363	10(3)	51
52	Certified Nurse Assistants/Aides	1,220 29,406	10(3)	52
53	TOTAL (lines 50 - 52)	4,213 \$ 154,769		53

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	
<u>Shailla Hart</u>	<u>Administrator</u>	<u>0</u>	\$ <u>48,041</u>	<u>Workers' Compensation Insurance</u>	\$ <u>16,451</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
				<u>Unemployment Compensation Insurance</u>	<u>29,038</u>	<u>Advertising: Employee Recruitment</u>	<u>2,525</u>	
				<u>FICA Taxes</u>	<u>88,058</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>(5,996)</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>97</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>327</u>	
				<u>Employee Relations</u>	<u>894</u>	<u>Home Office Allocation</u>	<u>734</u>	
				<u>Employee Retirement</u>	<u>208</u>	<u>Miscellaneous Licenses & Permits</u>	<u>408</u>	
				<u>Employee Life Insurance</u>	<u>10,000</u>	<u>LTC Solutions License</u>	<u>1,600</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>48,041</u>			<u>IHCA Dues</u>	<u>3,000</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	()	
B. Administrative - Other						<u>Non-allowable advertising</u>	()	
Description			Amount			<u>Yellow page advertising</u>	()	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>77,500</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>77,500</u>					
(Attach a copy of any management service agreement)								
C. Professional Services				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		\$ <u>2,025</u>				<u>Out-of-State Travel</u>	\$
<u>McGladrey & Pullen, LLC</u>	<u>Accounting Services</u>		<u>6,080</u>					
<u>Frontier</u>	<u>Computer Services</u>		<u>96</u>				<u>In-State Travel</u>	
<u>Mercer County Recorder</u>	<u>Legal Services</u>		<u>40</u>					
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>502</u>
							<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>8,241</u>				(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$ <u>502</u>

* Attach copy of IMRF notifications

**See instructions.

Aledo Rehab & Health Care Ctr

0047142

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,241

Home Office Allocation

Pearl & Associates	Legal	21
Addy Bush & Assoc	Legal	11
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	47
Duane Morris	Legal	73
Ginoli & Co.	Accountants	2,502
RSM McGladrey	Accountants	129
McGladrey & Pullen	Accountants	197
Emdeon Business Services	Computer Services	51
Advanced Answers on Demand	Computer Services	1,387
Access 2 Go	Computer Services	105
Ivans	Computer Services	92
Kemper Technology	Computer Services	217
Adminastar Federal	Computer Services	27
Logmein	Computer Services	17
E-Health Data Solutions	Computer Services	136
Miscellaneous Vendors	Computer Services	11

Total (agree to Schedule V, line 19, column 8)		<u>13,266</u>
--	--	---------------

Facility Name & ID Number Aledo Rehab & Health Care Ctr# 0047142Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$3,000
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,355 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. \$ 42,612
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,562
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? 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? No 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees