

Facility Name & ID Number Aledo Rehab & Health Care Center

0047142 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	29,280	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	29,280	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	14,755	6,934	1,993	23,682	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,755	6,934	1,993	23,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.88%

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 1,923

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Aledo Rehab & Health Care Center # 0047142 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	124,005	18,734		142,739		142,739	4,197	146,936		1
2	Food Purchase		144,577		144,577		144,577	(3,409)	141,168		2
3	Housekeeping	96,937	24,177		121,114		121,114	31	121,145		3
4	Laundry	35,475	10,603		46,078		46,078	2	46,080		4
5	Heat and Other Utilities			95,498	95,498		95,498	435	95,933		5
6	Maintenance	35,270	15,617	16,238	67,125		67,125	2,710	69,835		6
7	Other (specify):* Home Off. Ben. All.							1,032	1,032		7
8	TOTAL General Services	291,687	213,708	111,736	617,131		617,131	4,998	622,129		8
	B. Health Care and Programs										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	1,032,716	40,329	401,115	1,474,160		1,474,160	7,102	1,481,262		10
10a	Therapy	20,914		185,255	206,169		206,169		206,169		10a
11	Activities	60,148	1,122	497	61,767		61,767		61,767		11
12	Social Services	48,722		27	48,749		48,749		48,749		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,272	1,272		15
16	TOTAL Health Care and Programs	1,162,500	41,451	594,394	1,798,345		1,798,345	8,374	1,806,719		16
	C. General Administration										
17	Administrative	47,756		114,000	161,756		161,756	(81,327)	80,429		17
18	Directors Fees										18
19	Professional Services			7,826	7,826		7,826	9,317	17,143		19
20	Dues, Fees, Subscriptions & Promotions			15,833	15,833		15,833	993	16,826		20
21	Clerical & General Office Expenses	6,323	9,181	8,718	24,222		24,222	46,053	70,275		21
22	Employee Benefits & Payroll Taxes			278,762	278,762		278,762	7,935	286,697		22
23	Inservice Training & Education			730	730		730	249	979		23
24	Travel and Seminar							250	250		24
25	Other Admin. Staff Transportation			9,059	9,059		9,059	3,303	12,362		25
26	Insurance-Prop.Liab.Malpractice			15,860	15,860		15,860	197	16,057		26
27	Other (specify):* Home Off. Ben. All.							11,673	11,673		27
28	TOTAL General Administration	54,079	9,181	450,788	514,048		514,048	(1,357)	512,691		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,508,266	264,340	1,156,918	2,929,524		2,929,524	12,015	2,941,539		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 Center

#0047142

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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			68,876	68,876		68,876	6,609	75,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,100	98,100		98,100	19,955	118,055			32
33	Real Estate Taxes			25,970	25,970		25,970	599	26,569			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,568	7,568		7,568	511	8,079			35
36	Other (specify):*											36
37	TOTAL Ownership			200,514	200,514		200,514	27,674	228,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,090		47,090		47,090		47,090			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):* Non-allowable Cost		680	45,918	46,598		46,598	(46,598)				43
44	TOTAL Special Cost Centers		47,770	89,838	137,608		137,608	(46,598)	91,010			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,508,266	312,110	1,447,270	3,267,646		3,267,646	(6,909)	3,260,737			45

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

VI. ADJUSTMENT DETAIL

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

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

		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				4
5	Telephone, TV & Radio in Resident Rooms	(7,654)	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	54	30		9
10	Interest and Other Investment Income	(45)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(211)	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	(4,184)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(24,526)	43		24
25	Fund Raising, Advertising and Promotional	(4,189)	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	(9,828)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,683)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	43,774	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 43,774		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,909)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Aledo Rehab & Health Care Center

ID# 0047142

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,274)	43	1
2	X-Rays-Part A	(296)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(182)	10	3
4	Offset Miscellaneous Food Revenue	(3,478)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(184)	21	5
6	Offset Chamber of Commerce Dues	(250)	20	6
7	Disallowed Special Events	14	43	7
8	Resident Flowers	(178)	43	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
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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	(9,828)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	65	See Attached Schedule 6E		See Attached Sch 6E		
Jifi C. Jacob	10					
Cindy S. White	10					
Jacque Whitley	10					
David Petersen	5					

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.	65.00%	\$ 4,197	\$ 4,197	1
2	V	2 Food		Petersen Health Care, Inc.	65.00%	69	69	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	65.00%	31	31	3
4	V	4 Laundry		Petersen Health Care, Inc.	65.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	65.00%	435	435	5
6	V	6 Maintenance		Petersen Health Care, Inc.	65.00%	2,565	2,565	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	1,032	1,032	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	65.00%	7,284	7,284	8
9	V	11 Activities		Petersen Health Care, Inc.	65.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	1,272	1,272	10
11	V	17 Administrative	114,000	Petersen Health Care, Inc.	65.00%	32,673	(81,327)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	65.00%	3,688	3,688	12
13	V							13
14	Total		\$ 114,000			\$ 53,248	\$ * (60,752)	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.	65.00%	\$ 1,137	\$	1,137	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	65.00%	41,002		41,002	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	65.00%	249		249	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	65.00%	250		250	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	65.00%	3,228		3,228	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	65.00%	197		197	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	11,673		11,673	21
22	V	30 Depreciation		Petersen Health Care, Inc.	65.00%	4,467		4,467	22
23	V	32 Interest		Petersen Health Care, Inc.	65.00%	3,142		3,142	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	65.00%	599		599	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	65.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	65.00%	511		511	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		\$			\$ 66,455	\$ *	66,455	39

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

Facility Name & ID Number Aledo Rehab & Health Care Center# 0047142Report Period Beginning: 1/1/2008Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Enterprises, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Enterprises, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Enterprises, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Enterprises, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Enterprises, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	145	145	21	
22	V	10 Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Enterprises, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Enterprises, LLC	100.00%	0		25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	5,629	5,629	26	
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	106	106	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	5,235	5,235	28	
29	V	23 Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	7,935	7,935	29	
30	V	24 Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	75	75	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Enterprises, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	2,088	2,088	35	
36	V	33 Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	16,858	16,858	36	
37	V	34 Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38	
39	Total		\$			\$ 38,071	\$ *	38,071	39

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

Facility Name & ID Number

Aledo Rehab & Health Care Center

0047142

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	65.00	1,796,001	0.98	1.63	Salary	32,673	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00						L21, C7	2
3	Cindy S. White	Owner	Administrative	10.00	104,753	1.00	1.67	Salary	1,906	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	93,886	1.00	1.67	Salary	1,708	L10, C7	4
5	David Petersen	Owner	Administrative	5.00							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,287		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 Center# 0047142 Report Period Beginning: 1/1/2008Ending: 2/31/2008

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	1,413,604	69	\$ 251,260	\$ 250,687	23,613	\$ 4,197	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	23,613	69	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	23,613	31	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	23,613	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	23,613	435	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	23,613	2,565	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	23,613	1,032	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	23,613	7,284	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	23,613	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	23,613	1,272	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	23,613	32,673	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	23,613	3,688	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	23,613	1,137	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	23,613	41,002	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	23,613	249	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	23,613	250	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	23,613	3,228	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	23,613	197	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	23,613	11,673	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	23,613	4,467	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	23,613	3,142	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	23,613	599	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	23,613	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	23,613	511	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 119,703	25

Facility Name & ID Number Aledo Rehab & Health Care Center# 0047142 Report Period Beginning: 1/1/2008Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health 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

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	95,327	5	\$	23,613	\$	1
2	2	Food	Resident Days	95,327	5		23,613		2
3	3	Housekeeping	Resident Days	95,327	5		23,613		3
4	4	Laundry	Resident Days	95,327	5		23,613		4
5	5	Utilities	Resident Days	95,327	5		23,613		5
6	6	Maintenance	Resident Days	95,327	5	585	23,613	145	6
7	7	Mgmt. Allocation of Benefits	Resident Days	95,327	5		23,613		7
8	10	Nursing and Medical Records	Resident Days	95,327	5		23,613		8
9	15	Mgmt. Allocation of Benefits	Resident Days	95,327	5		23,613		9
10	17	Administrative	Resident Days	95,327	5		23,613		10
11	19	Professional Services	Resident Days	95,327	5	22,726	23,613	5,629	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	95,327	5	427	23,613	106	12
13	21	Clerical and General Office	Resident Days	95,327	5	21,132	23,613	5,235	13
14	22	Employee Benefits & Payroll	Resident Days	95,327	5	32,035	23,613	7,935	14
15	23	Inservice Training & Education	Resident Days	95,327	5		23,613		15
16	24	Travel and Seminar	Resident Days	95,327	5		23,613		16
17	25	Other Admin. Staff Transport.	Resident Days	95,327	5	301	23,613	75	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	95,327	5		23,613		18
19	27	Mgmt. Allocation of Benefits	Resident Days	95,327	5		23,613		19
20	30	Depreciation	Resident Days	95,327	5	8,430	23,613	2,088	20
21	32	Interest	Resident Days	95,327	5	68,058	23,613	16,858	21
22	33	Real Estate Taxes	Resident Days	95,327	5		23,613		22
23	34	Rent-Facility and Grounds	Resident Days	95,327	5		23,613		23
24	35	Rent-Equipment & Vehicles	Resident Days	95,327	5		23,613		24
25	TOTALS					\$ 153,694	\$	\$ 38,071	25

Facility Name & ID Number

Aledo Rehab & Health Care Center

0047142

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	5/6/2008	\$ 1,253,260	\$ 1,153,965	5/6/2011	0.0695	\$ 93,930	1						
2												2						
3							Interest Income Offset				(45)	3						
4							Home Office Allocation-PHC				3,142	4						
5							Home Office Allocation-PHE				16,858	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$10,166.00		\$ 1,253,260	\$ 1,153,965			\$ 113,885	9						
B. Non-Facility Related*																		
10												10						
11							Amortization of Mortgage Costs				4,170	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 4,170	14						
15	TOTALS (line 9+line14)						\$ 1,253,260	\$ 1,153,965			\$ 118,055	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 2007 report.		\$	27,000	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.)	2007	\$	25,970	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,030)	3
4. Real Estate Tax accrual used for 2008 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			599	
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.		\$	26,569	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	24,341	8
	2004	27,991	9
	2005	24,033	10
	2006	25,608	11
	2007	25,970	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aledo Rehab & Health Care Center COUNTY Mercer

FACILITY IDPH LICENSE NUMBER 0047142

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

	(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>25,970.46</u>	\$ <u>25,970.46</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>25,970.46</u>	\$ <u>25,970.46</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 Center

0047142

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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	\$ 124,861	4
5											5
6											6
7	Home Office Allocation										7
8											8
	Improvement Type**										
9	Nurse Call CE & Hardware		2005		2,698		5	540	540	1,980	9
10	Company Sign		2005		2,537		10	254	254	889	10
11	Carpet		2005		1,681		10	168	168	518	11
12	Sidewalks		2006		9,946		20	497	497	1,243	12
13	Sidewalks		2006		20,675		20	1,034	1,034	2,585	13
14	Boiler System		2007		16,250		15	1,083	1,083	1,625	14
15	Alarm System		2007		1,003		10	100	100	150	15
16	Kitchen Drain Line		2008		5,968		25	119	119	119	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

*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			34,053			(34,053)		44
45			3,264			(3,264)		45
46								46
47								47
48		820			53	53		48
49		12,261			294	294		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		\$ 1,095,439	\$ 37,317		\$ 38,195	\$ 878	\$ 133,970	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	\$ 283,904	\$ 31,002	\$ 30,257	\$ (745)	5-10 yrs.	\$ 108,887	71
72	Current Year Purchases	9,552	557	478	(79)	10 yrs.	478	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,555	6,555			74
75	TOTALS	\$ 293,456	\$ 31,559	\$ 37,290	\$ 5,731		\$ 109,365	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)	\$ 1,438,895	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,485	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,609	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 243,335	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,079 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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 Center

0047142

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	3,207
Dishwasher		712
Laundry Equipment		1,019
Copier		2,630
Home Office Allocation		511
		<u>8,079</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	\$	5,688	\$ 85,317	\$	5,688	\$ 85,317	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		413	6,195		413	6,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	1497 hrs	20,914	6,250	93,743		7,747	114,657	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				47,090		47,090	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 20,914	12,351	\$ 185,255	\$ 47,090	13,848	\$ 253,259	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (164,889)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (164,891)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(480,762)	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)	\$ (480,762)	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)	\$ (645,653)	24 *

* This must agree with page 17, line 47.

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	\$ 2,329,871	1
2	Discounts and Allowances for all Levels	129,767	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,459,638	3
	B. Ancillary Revenue		
4	Day Care	3,274	4
5	Other Care for Outpatients		5
6	Therapy	238,793	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 242,067	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	3,478	14
15	Telephone, Television and Radio	378	15
16	Rental of Facility Space		16
17	Sale of Drugs	69,238	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,223	20
21	Other Medical Services	5,451	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 84,768	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	45	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 45	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	366	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 366	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,786,884	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	617,131	31
32	Health Care	1,798,345	32
33	General Administration	514,048	33
	B. Capital Expense		
34	Ownership	200,514	34
	C. Ancillary Expense		
35	Special Cost Centers	93,688	35
36	Provider Participation Fee	43,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,267,646	40
41	Income before Income Taxes (line 30 minus line 40)**	(480,762)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (480,762)	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 part of 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 Center**

0047142

Report Period Beginning: **1/1/2008**

Ending:

12/31/2008

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	\$ 57,750	\$ 27.76	1
2	Assistant Director of Nursing	2,080	2,080	39,925	19.19	2
3	Registered Nurses	4,595	4,858	116,079	23.89	3
4	Licensed Practical Nurses	11,934	12,391	227,703	18.38	4
5	CNAs & Orderlies	48,112	49,046	572,379	11.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,457	1,497	20,914	13.97	8
9	Activity Director	2,006	2,030	26,207	12.91	9
10	Activity Assistants	4,130	4,203	33,941	8.08	10
11	Social Service Workers	3,908	4,047	48,722	12.04	11
12	Dietician					12
13	Food Service Supervisor	1,229	1,229	16,253	13.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,967	13,464	107,752	8.00	15
16	Dishwashers					16
17	Maintenance Workers	2,982	3,041	35,270	11.60	17
18	Housekeepers	11,699	11,750	96,937	8.25	18
19	Laundry	4,328	35,475	35,475	1.00	19
20	Administrator	2,080	2,080	47,756	22.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	610	610	6,323	10.37	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	1,781	1,995	18,880	9.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,978	151,876	\$ 1,508,266 *	\$ 9.93	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	7,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	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	1 visit	27	10(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,627		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	25	\$ 1,150	10(3)	50
51	Licensed Practical Nurses	744	26,625	10(3)	51
52	Certified Nurse Assistants/Aides	13,860	371,831	10(3)	52
53	TOTAL (lines 50 - 52)	14,629	\$ 399,606		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>47,756</u>	<u>Workers' Compensation Insurance</u>	\$ <u>125,731</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>30,179</u>	<u>Advertising: Employee Recruitment</u>	<u>4,107</u>	
				<u>FICA Taxes</u>	<u>111,247</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>8,409</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>322</u> <u>3,226</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>400</u>	
				<u>Employee Relations</u>	<u>10,850</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>330</u>	
				<u>Employee Retirement</u>	<u>236</u>	<u>IHCA Dues</u>	<u>5,780</u>	
				<u>Smoking Cessation Reimbursement</u>	<u>45</u>	<u>Home Office Allocation</u>	<u>1,243</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>47,756</u>			<u>Less: Public Relations Expense</u>	<u>(250)</u>	
(List each licensed administrator separately.)						<u>Non-allowable advertising</u>	<u>()</u>	
B. Administrative - Other						<u>Yellow page advertising</u>	<u>()</u>	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>114,000</u>	\$ <u>286,697</u>		\$ <u>16,826</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>114,000</u>					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
<u>E-Health Data Solutions</u>	<u>Computer Services</u>	\$ <u>2,700</u>					<u>Out-of-State Travel</u>	\$
<u>Frontier</u>	<u>Computer Services</u>	<u>133</u>						
<u>LTC Solutions</u>	<u>Computer Services</u>	<u>1,600</u>					<u>In-State Travel</u>	
<u>Lindon Engineering</u>	<u>Accounting Services</u>	<u>3,393</u>						
				<u>N/A</u>				
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>250</u>
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>7,826</u>	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ <u>250</u>	

* Attach copy of IMRF notifications

**See instructions.

Aledo Rehab & Health Care Center

0047142

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,826

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	134
GoffWilson, P.A.	Legal	448
Ginoli & Company	Accountants	6,717
RSM McGladrey	Accountants	10
Miscellaneous Vendors	Computer Services	52
Emdeon Business Services	Computer Services	72
Advanced Answers on Demand	Computer Services	847
Access 2 Go	Computer Services	250
Ivans	Computer Services	130
Kemper Technology	Computer Services	459
VisionShare	Computer Services	49
Logmein	Computer Services	35
Comm Net Communiations	Computer Services	13
Charter Communications	Computer Services	11
Advanced System Designs	Computer Services	16
Consolidated Communications	Computer Services	10
Miscellaneous Vendors	Miscellaneous	64

Total (agree to Schedule V, line 19, column 8)	<u>17,143</u>
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Aledo Rehab & Health Care Center

0047142

Period Beginning **1/1/2008** **1/1/2008**

Period End **12/31/2008** **12/31/2008**

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shaila Hart	Administrator	0	47,756
		Total	<u>47,756</u>

Facility Name & ID Number Aledo Rehab & Health Care Center# 0047142Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 5,780 -IHCA
- (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? No
- (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. \$ 5,954 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? N/A
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. \$ 43,920
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. \$ 3,478
- (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. \$ No
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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