

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047142

Facility Name: Aledo Health and Rehabilitation Center

Address: 304 SW 12th Street Aledo 61231
Number City Zip Code

County: Mercer

Telephone Number: (309) 582-5376 Fax # (309) 582-2435

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2005

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Aledo Health and Rehabilitation Center

0047142 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 <u>N/A</u>					
	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,296	5,733	1,310	16,339	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,296	5,733	1,310	16,339	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.96%

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 1,163

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: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Aledo Health and Rehabilitation Center # 0047142 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	132,063	9,854		141,917		141,917	3,296	145,213			1
2	Food Purchase		108,755		108,755		108,755	(3,116)	105,639			2
3	Housekeeping	71,329	19,109	547	90,985		90,985	21	91,006			3
4	Laundry	32,087	10,998		43,085		43,085		43,085			4
5	Heat and Other Utilities			71,948	71,948		71,948	216	72,164			5
6	Maintenance	31,261	8,623	20,483	60,367		60,367	1,344	61,711			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							752	752			7
8	TOTAL General Services	266,740	157,339	92,978	517,057		517,057	2,513	519,570			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	928,271	62,246	3,896	994,413		994,413	33	994,446			10
10a	Therapy			133,700	133,700		133,700		133,700			10a
11	Activities	30,434	305	240	30,979		30,979	(2,694)	28,285			11
12	Social Services	26,707	10		26,717		26,717		26,717			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	985,412	62,561	143,836	1,191,809		1,191,809	(2,661)	1,189,148			16
	C. General Administration											
17	Administrative			69,600	69,600		69,600	(10,807)	58,793			17
18	Directors Fees											18
19	Professional Services			11,691	11,691		11,691	(2,242)	9,449			19
20	Dues, Fees, Subscriptions & Promotions			4,733	4,733		4,733	15	4,748			20
21	Clerical & General Office Expenses	9,838	4,426	4,621	18,885		18,885	32,601	51,486			21
22	Employee Benefits & Payroll Taxes			201,505	201,505		201,505		201,505			22
23	Inservice Training & Education			67	67		67	110	177			23
24	Travel and Seminar							32	32			24
25	Other Admin. Staff Transportation			5,748	5,748		5,748	2,824	8,572			25
26	Insurance-Prop.Liab.Malpractice			27,091	27,091		27,091	764	27,855			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							12,490	12,490			27
28	TOTAL General Administration	9,838	4,426	325,056	339,320		339,320	35,787	375,107			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,261,990	224,326	561,870	2,048,186		2,048,186	35,639	2,083,825			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			71,084	71,084		71,084	8,471	79,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5,241	5,241			32
33	Real Estate Taxes			31,609	31,609		31,609	272	31,881			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,845	15,845		15,845	481	16,326			35
36	Other (specify):*											36
37	TOTAL Ownership			118,538	118,538		118,538	14,465	133,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,358		57,358		57,358		57,358			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* Non-allowable Costs	17,229	744	35,868	53,841		53,841	(53,841)				43
44	TOTAL Special Cost Centers	17,229	58,102	79,668	154,999		154,999	(53,841)	101,158			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,279,219	282,428	760,076	2,321,723		2,321,723	(3,737)	2,317,986			45

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

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,131)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,651)	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	4,056	30		9
10	Interest and Other Investment Income	(73)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(179)	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	(1,363)	43		18
19	Entertainment				19
20	Contributions	(232)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,301)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,221)	43		24
25	Fund Raising, Advertising and Promotional	(21,744)	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 Page 5A</u>	(12,978)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,817)		\$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	60,080	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 60,080		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,737)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (7,639)	43	1
2	X-Rays-Part A	(255)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(583)	21	3
4	Offset Transportation Revenue	(2,694)	11	4
5	Disallowed Special Events	(918)	43	5
6	Disallowed Chamber of Commerce Dues	(250)	20	6
7	Resident Flowers	(639)	43	7
8				8
9				9
10				10
11				11
12				12
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,978)		49

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,296	\$ 3,296	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	15	15	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	216	216	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,344	1,344	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	752	752	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	33	33	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%	0		10
11	V	17	Administrative	69,600	Petersen Health Care, Inc.	100.00%	58,793	(10,807)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,771	3,771	12
13	V								13
14	Total			\$ 69,600			\$ 68,241	\$ * (1,359)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 265	\$ 265	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	30,728	30,728	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	110	110	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	32	32	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,824	2,824	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	764	764	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,490	12,490	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,415	4,415	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,314	5,314	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	272	272	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	481	481	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			\$			\$ 57,695	\$ * 57,695	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Midwest Health Properties, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Midwest Health Properties, LLC	100.00%	0		16
17	V	3	Housekeeping		Midwest Health Properties, LLC	100.00%	0		17
18	V	4	Laundry		Midwest Health Properties, LLC	100.00%	0		18
19	V	5	Utilities		Midwest Health Properties, LLC	100.00%	0		19
20	V	6	Maintenance		Midwest Health Properties, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Midwest Health Properties, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		23
24	V	17	Administrative		Midwest Health Properties, LLC	100.00%	0		24
25	V	19	Professional Services		Midwest Health Properties, LLC	100.00%	1,288	1,288	25
26	V	20	Dues, Fees, Subs & Promotions		Midwest Health Properties, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Midwest Health Properties, LLC	100.00%	2,456	2,456	27
28	V	22	Employee Benefits & Payroll		Midwest Health Properties, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Midwest Health Properties, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Midwest Health Properties, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Midwest Health Properties, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Properties, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		33
34	V	30	Depreciation		Midwest Health Properties, LLC	100.00%	0		34
35	V	32	Interest		Midwest Health Properties, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Midwest Health Properties, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Midwest Health Properties, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Properties, LLC	100.00%	0		38
39	Total			\$			\$ 3,744	\$ * 3,744	39

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

Facility Name & ID Number

Aledo Health and Rehabilitation Center

0047142

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0047142

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Aledo Health and Rehabilitation Center

0047142

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	1,542,131	77	\$ 311,109	\$ 308,619	16,339	\$ 3,296	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	16,339	15	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	16,339	21	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	16,339	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	16,339	216	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	16,339	1,344	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	16,339	752	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	16,339	33	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	16,339	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	16,339	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	16,339	58,793	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	16,339	3,771	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	16,339	265	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	16,339	30,728	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	16,339	110	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	16,339	32	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	16,339	2,824	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	16,339	764	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	16,339	12,490	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	16,339	4,415	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	16,339	5,314	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	16,339	272	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	16,339	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	16,339	481	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 125,936	25

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0047142

Report Period Beginning:

1/1/2011Ending: 2/31/2011

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

Midwest Health Properties, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	89,235	7	\$	\$	16,339	\$	1
2	2	Food	Resident Days	89,235	7			16,339		2
3	3	Housekeeping	Resident Days	89,235	7			16,339		3
4	4	Laundry	Resident Days	89,235	7			16,339		4
5	5	Utilities	Resident Days	89,235	7			16,339		5
6	6	Maintenance	Resident Days	89,235	7			16,339		6
7	7	Mgmt. Allocation of Benefits	Resident Days	89,235	7			16,339		7
8	10	Nursing and Medical Records	Resident Days	89,235	7			16,339		8
9	15	Mgmt. Allocation of Benefits	Resident Days	89,235	7			16,339		9
10	17	Administrative	Resident Days	89,235	7			16,339		10
11	19	Professional Services	Resident Days	89,235	7	7,036		16,339	1,288	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	89,235	7			16,339		12
13	21	Clerical and General Office	Resident Days	89,235	7	13,414		16,339	2,456	13
14	22	Employee Benefits & Payroll	Resident Days	89,235	7			16,339		14
15	23	Inservice Training & Education	Resident Days	89,235	7			16,339		15
16	24	Travel and Seminar	Resident Days	89,235	7			16,339		16
17	25	Other Admin. Staff Transport.	Resident Days	89,235	7			16,339		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	89,235	7			16,339		18
19	27	Mgmt. Allocation of Benefits	Resident Days	89,235	7			16,339		19
20	30	Depreciation	Resident Days	89,235	7			16,339		20
21	32	Interest	Resident Days	89,235	7			16,339		21
22	33	Real Estate Taxes	Resident Days	89,235	7			16,339		22
23	34	Rent-Facility and Grounds	Resident Days	89,235	7			16,339		23
24	35	Rent-Equipment & Vehicles	Resident Days	89,235	7			16,339		24
25	TOTALS					\$ 20,450	\$		\$ 3,744	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$				\$
2											
3											
4											
5											
	Working Capital										
6											
7											
8											
9	TOTAL Facility Related						\$				\$
	B. Non-Facility Related*										
10								Interest Income Offset			(73)
11								Home Office Allocation-PHC			5,314
12											
13											
14	TOTAL Non-Facility Related						\$				\$ 5,241
15	TOTALS (line 9+line14)						\$				\$ 5,241

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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	31,620	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.)		2010		\$	31,129	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(491)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	32,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	272	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	31,881	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	25,608	8		
		2007	25,970	9		
		2008	29,415	10		
		2009	30,661	11		
		2010	31,129	12		
Accrual based on prior year tax bill.						

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Aledo Health and Rehabilitation 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 2010 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 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-10-20-302-002	Long-Term Care Facility	\$ 31,128.84	\$ 31,128.84
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 31,128.84	\$ 31,128.84

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		2005	1973	\$ 1,021,600	\$	30	\$ 34,053	\$ 34,053	\$ 227,020	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call CE & Hardware			2005	2,698		5			2,698	9
10	Company Sign			2005	2,537		10	254	254	1,651	10
11	Carpet			2005	1,681		10	168	168	1,022	11
12	Sidewalks			2006	9,946		20	497	497	2,734	12
13	Sidewalks			2006	20,675		20	1,034	1,034	5,687	13
14	Boiler System			2007	16,250		15	1,083	1,083	4,874	14
15	Alarm System			2007	1,003		10	100	100	450	15
16	Kitchen Drain Line			2008	5,968		25	238	238	833	16
17	Water Heater			2009	6,200		5	1,240	1,240	3,100	17
18	Generator Repair			2009	4,413		7	630	630	1,536	18
19	Asphalt Resurfacing			2009	19,335		10	1,934	1,934	4,835	19
20	Sprinkler Repair System			2010	5,370		7	768	768	1,152	20
21	Painting of Exterior of Facility			2010	7,077		15	472	472	708	21
22	Rooftop A/C Unit			2011	6,781		15	226	226	226	22
23	Retaining Wall			2011	4,285		15	143	143	143	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.**

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Land Improvements Booked			3,975			(3,975)		60
61	Building Booked			34,053			(34,053)		61
62	Building Improvement Booked			4,406			(4,406)		62
63									63
64									64
65	2011-Home Office Allocation-Land Improvements		726			46	46		65
66	2011-Home Office Allocation-Building Improvements		7,777			187	187		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,144,322	\$ 42,434		\$ 43,073	\$ 639	\$ 258,669	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 320,588	\$ 28,650	\$ 32,300	\$ 3,650	5-10 yrs.	\$ 205,102	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,182	4,182			74
75	TOTALS	\$ 320,588	\$ 28,650	\$ 36,482	\$ 7,832		\$ 205,102	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets			1	2
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,514,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,084	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,555	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,471	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 463,771	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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
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: \$ 16,326 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. /2012 \$
13. /2013 \$
14. /2014 \$

* 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 Health and Rehabilitation Center
0047142

Period Beginning	<u>1/1/2011</u>
Period End	<u>12/31/2011</u>

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$ 11,412
Dishwasher	1,008
Laundry Equipment	850
Copier	2,575
Home Office Allocation	<u>481</u>
	<u>16,326</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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? 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.	☐ YES ☒ NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER CNA	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER CNA
---	---	---	---

B. EXPENSES

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

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	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,795	\$ 56,930	\$	3,795	\$ 56,930	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		298	4,470		298	4,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,783	71,750		4,783	71,750	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				57,358		57,358	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			37	550		37	550	13
14	TOTAL			\$	8,913	\$ 133,700	\$ 57,358	8,913	\$ 191,058	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,918	\$ 19,918	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	449,131	449,131	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,393	22,393	6
7	Other Prepaid Expenses	53,631	53,631	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	3,988	3,988	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 549,061	\$ 549,061	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	99,956	50,000	13
14	Buildings, at Historical Cost	1,021,600	1,029,377	14
15	Leasehold Improvements, at Historical Cost	48,013	114,945	15
16	Equipment, at Historical Cost	320,588	320,588	16
17	Accumulated Depreciation (book methods)	(456,598)	(463,771)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,033,559	\$ 1,051,139	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,582,620	\$ 1,600,200	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 431,051	\$ 431,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,854	88,854	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	4,531	4,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,100	32,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	74,628	74,628	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 631,164	\$ 631,164	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Related Party</u>	11,177	11,177	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,177	\$ 11,177	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 642,341	\$ 642,341	46
47	TOTAL EQUITY(page 18, line 24)	\$ 940,279	\$ 957,859	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,582,620	\$ 1,600,200	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,607,016)	1
2	Restatements (describe):		2
3	Rounding	1	3
4	Prior Period Adjustment-Accrued Management Fees	(110,003)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,717,018)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(192,281)	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	(184,282)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Transfer of Net assets	3,033,860	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,657,297	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)	\$ 940,279	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aledo Health and Rehabilitation Center**# **0047142**Report Period Beginning: **1/1/2011**Ending: **12/31/2011**

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	\$ 1,906,098	1
2	Discounts and Allowances for all Levels	(147,557)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,758,541	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,302	6
7	Oxygen	746	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,048	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	3,131	14
15	Telephone, Television and Radio	44	15
16	Rental of Facility Space		16
17	Sale of Drugs	133,920	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,167	20
21	Other Medical Services	5,241	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 150,503	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 73	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	583	28
28a	Transportation Revenue	2,694	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,277	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,129,442	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	517,057	31
32	Health Care	1,191,809	32
33	General Administration	339,320	33
	B. Capital Expense		
34	Ownership	118,538	34
	C. Ancillary Expense		
35	Special Cost Centers	111,199	35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,321,723	40
41	Income before Income Taxes (line 30 minus line 40)**	(192,281)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (192,281)	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 Health and Rehabilitation Center**# **0047142**

Report Period Beginning:

1/1/2011

Ending:

12/31/2011**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,929	1,929	\$ 50,898	\$ 26.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,254	4,653	115,621	24.85	3
4	Licensed Practical Nurses	11,549	12,396	255,140	20.58	4
5	CNAs & Orderlies	34,409	36,107	465,096	12.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,924	3,097	30,434	9.83	10
11	Social Service Workers	1,853	1,917	26,707	13.93	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,502	13.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,314	11,613	103,561	8.92	15
16	Dishwashers					16
17	Maintenance Workers	2,067	2,123	31,261	14.72	17
18	Housekeepers	7,972	8,020	71,329	8.89	18
19	Laundry	3,454	3,710	32,087	8.65	19
20	Administrator	2,215	2,223	58,793	26.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	741	911	9,838	10.80	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	298	298	3,019	10.13	31
32	Other Health Care: <u>Care Plan Coord</u>	1,560	1,700	38,497	22.65	32
33	Other(specify) <u>Marketing</u>	1,128	1,128	17,229	15.27	33
34	TOTAL (lines 1 - 33)	89,747	93,905	\$ 1,338,012 *	\$ 14.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,938	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)		\$ 8,938		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Scott Widener	Adminstrator	0	\$ 19,903
Lauren Elgin	Adminstrator	0	38,890
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,793
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 69,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 69,600
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 3,485
Frontier	Computer Services		779
Honkamp Krueger & Co.	Accounting Fees		126
Mercer County Recorder	Filing Fees		45
Mercer County Circuit Clerk	Filing Fees		256
Med-Staff, Inc.	Legal Fees		7,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,691
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 37,294
Unemployment Compensation Insurance			28,578
FICA Taxes			104,476
Employee Health Insurance			30,850
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			150
Employee Retirement			109
Life Insurance			48
TOTAL (agree to Schedule V, line 22, col.8)			\$ 201,505
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			2,486
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	67		674
Miscellaneous Licenses & Permits			1,233
Miscellaneous Dues & Subscriptions			340
Home Office Allocation			265
Less: Public Relations Expense			(250)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,748
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			32
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 32

*** Attach copy of IMRF notifications**

****See instructions.**

Aledo Health and Rehabilitation Center
0047142

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,691
Disallowed legal fees		(7,301)

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	
Ginoli & Company	Accountants	1,812
Miscellaneous Vendors	Computer Services	42
Advanced Answers on Demand	Computer Services	2,187
Access 2 Go	Computer Services	215
Kemper Technology	Computer Services	100
MediFax	Computer Services	34
VisionShare	Computer Services	154
Advanced System Design	Computer Services	201
Simple LTC	Computer Services	253
Optimizer Systems	Other Prof Fees	26
Clifton Gunderson	Other Prof Fees	9
Mike Miller	Other Prof Fees	12
OIC Group	Other Prof Fees	3
All Scripts	Other Prof Fees	7
Total (agree to Schedule V, line 19, column 8)		<u>9,449</u>

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____

(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? N/A

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,036 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. \$ 43,800
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,131

(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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 424
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company

(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