

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

<p>I. IDPH License ID Number: <u>0051300</u></p> <p>Facility Name: <u>Aledo Rehab & Hlth Care Ctr</u></p> <p>Address: <u>304 SW 12th Street</u> <u>Aledo</u> <u>61231</u> <small>Number City Zip Code</small></p> <p>County: <u>Mercer</u></p> <p>Telephone Number: <u>(309) 582-5376</u> Fax # <u>(309) 582-2435</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/1/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,095	6,874	757	21,726	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,095	6,874	757	21,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.40%

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

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 652

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: 12/31/14 Fiscal Year: 12/31/14

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

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	135,756	12,356		148,112		148,112	7,343	155,455		1
2	Food Purchase		166,330		166,330		166,330	(1,699)	164,631		2
3	Housekeeping	85,841	39,181		125,022		125,022	45	125,067		3
4	Laundry	25,381	13,589		38,970		38,970		38,970		4
5	Heat and Other Utilities			74,828	74,828		74,828	276	75,104		5
6	Maintenance	31,277	12,771	14,837	58,885		58,885	2,761	61,646		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	278,255	244,227	89,665	612,147		612,147	8,726	620,873		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	26	6,026		9
10	Nursing and Medical Records	997,056	47,242	6,328	1,050,626		1,050,626	21	1,050,647		10
10a	Therapy			147,648	147,648		147,648		147,648		10a
11	Activities	59,191			59,191		59,191	(687)	59,191		11
12	Social Services	22,587			22,587		22,587		22,587		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,078,834	47,242	159,976	1,286,052		1,286,052	(640)	1,286,099		16
	C. General Administration										
17	Administrative			129,400	129,400		129,400	(76,861)	52,539		17
18	Directors Fees										18
19	Professional Services			4,500	4,500		4,500	19,743	24,243		19
20	Dues, Fees, Subscriptions & Promotions			380	380		380	425	805		20
21	Clerical & General Office Expenses	22,001	2,333	16,691	41,025		41,025	81,375	122,400		21
22	Employee Benefits & Payroll Taxes			198,254	198,254		198,254	17,329	215,583		22
23	Inservice Training & Education							33	33		23
24	Travel and Seminar							28	28		24
25	Other Admin. Staff Transportation			6,480	6,480		6,480	4,459	10,939		25
26	Insurance-Prop.Liab.Malpractice			27,328	27,328		27,328	643	27,971		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	22,001	2,333	383,033	407,367		407,367	47,174	454,541		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,379,090	293,802	632,674	2,305,566		2,305,566	55,260	2,361,513		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 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			74,576	74,576		74,576	7,898	82,474			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							2,018	2,018			32
33	Real Estate Taxes			30,594	30,594		30,594	256	30,850			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,200	13,200		13,200	1,087	14,287			35
36	Other (specify):*											36
37	TOTAL Ownership			118,370	118,370		118,370	11,259	129,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,510		19,510		19,510		19,510			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,223	181,223		181,223		181,223			42
43	Other (specify):*	30,598		101,068	131,666		131,666	(131,666)				43
44	TOTAL Special Cost Centers	30,598	19,510	282,291	332,399		332,399	(131,666)	200,733			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,409,688	313,312	1,033,335	2,756,335		2,756,335	(65,147)	2,691,875			45

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning: 1/1/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,785)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,303)	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	2,483	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	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	(26,502)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,305)	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 Page 5A	(35,234)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,888)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	66,741	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 66,741		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (65,147)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Aledo Rehab & Hlth Care Ctr

ID# 0051300

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,314)	43	1
2	X-Rays-Part A	(1,518)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(117)	21	3
4	Offset Transportation Revenue	(687)	11	4
5	Disallowed Special Events		43	5
6	Disallowed Marketing Expense	(30,598)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(35,234)	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%	\$ 3,198	\$ 3,198	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	77	77	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	16	16	3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	216	216	4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,214	1,214	5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	26	26	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8	
9	V	10A TherUy		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		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,758	2,758	12	
13	V							13	
14	Total		\$			\$ 7,506	\$ *	7,506	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%	\$ 154	\$	154	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,004		36,004	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,637		1,637	17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	18		18	18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	11		11	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,912		2,912	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	513		513	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,940		2,940	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,870		1,870	24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	144		144	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	740		740	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		\$			\$ 46,943	\$ *	46,943	39

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr# 0051300Report Period Beginning: 1/1/14Ending: 12/31/14

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%	10,754	10,754	25
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Properties, LLC	100.00%	221	221	26
27	V	21 Clerical and General Office		Midwest Health Properties, LLC	100.00%	0		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%	2,276	2,276	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		\$			\$ 13,251	\$ *	13,251

* 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	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,145	\$ 4,145
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	9	9
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	29	29
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	60	60
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,547	1,547
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	20	20
23	V	10A TherUy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	129,400	Petersen Health Care Management, Inc.	100.00%	52,539	(76,861)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	6,231	6,231
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	50	50
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	45,488	45,488
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	15,692	15,692
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	15	15
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	17	17
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,547	1,547
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	130	130
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	199	199
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	264	264
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	112	112
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	347	347
39	Total		\$ 129,400			\$ 128,441	\$ * (959)

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

Facility Name & ID Number

Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	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 Syste	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	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	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 C	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	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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 Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

Facility Name & ID Number

Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0051300 Report Period Beginning: 1/1/14 Ending: 12/31/14

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											4
5											5
6	N/A										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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	1,572,338	77	\$ 231,473	\$ 220,289	21,726	\$ 3,198	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	21,726	77	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	21,726	16	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	21,726	216	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	21,726	1,214	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,726	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	21,726	26	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	21,726	1	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	21,726	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,726	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	21,726	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	21,726	2,758	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	21,726	154	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	21,726	36,004	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	21,726	1,637	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	21,726	18	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	21,726	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	21,726	2,912	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	21,726	513	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	21,726	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	21,726	2,940	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	21,726	1,870	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	21,726	144	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	21,726	740	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 54,449	25

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	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	143,856	10		21,726		1
2	2	Food	Resident Days	143,856	10		21,726		2
3	3	Housekeeping	Resident Days	143,856	10		21,726		3
4	4	Laundry	Resident Days	143,856	10		21,726		4
5	5	Utilities	Resident Days	143,856	10		21,726		5
6	6	Maintenance	Resident Days	143,856	10		21,726		6
7	7	Mgmt. Allocation of Benefits	Resident Days	143,856	10		21,726		7
8	10	Nursing and Medical Records	Resident Days	143,856	10		21,726		8
9	15	Mgmt. Allocation of Benefits	Resident Days	143,856	10		21,726		9
10	17	Administrative	Resident Days	143,856	10		21,726		10
11	19	Professional Services	Resident Days	143,856	10	71,207	21,726	10,754	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	143,856	10	1,462	21,726	221	12
13	21	Clerical and General Office	Resident Days	143,856	10		21,726		13
14	22	Employee Benefits & Payroll	Resident Days	143,856	10		21,726		14
15	23	Inservice Training & Education	Resident Days	143,856	10		21,726		15
16	24	Travel and Seminar	Resident Days	143,856	10		21,726		16
17	25	Other Admin. Staff Transport.	Resident Days	143,856	10		21,726		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	143,856	10		21,726		18
19	27	Mgmt. Allocation of Benefits	Resident Days	143,856	10		21,726		19
20	30	Depreciation	Resident Days	143,856	10	15,073	21,726	2,276	20
21	32	Interest	Resident Days	143,856	10		21,726		21
22	33	Real Estate Taxes	Resident Days	143,856	10		21,726		22
23	34	Rent-Facility and Grounds	Resident Days	143,856	10		21,726		23
24	35	Rent-Equipment & Vehicles	Resident Days	143,856	10		21,726		24
25	TOTALS					\$ 87,742	\$	\$ 13,251	25

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 Management, 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	1,572,338	77	\$ 231,473	\$ 294,997	21,726	\$ 4,145	1
2	2	Food	Resident Days	1,572,338	77	5,537		21,726	9	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	558	21,726	29	3
4	5	Utilities	Resident Days	1,572,338	77	15,618		21,726	60	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	94,000	21,726	1,547	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,726		6
7	9	Medical Director	Resident Days	1,572,338	77	1,878		21,726		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71		21,726	20	8
9	10A	TherUy	Resident Days	1,572,338	77			21,726		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,726		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	21,726	52,539	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631		21,726	6,231	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115		21,726	50	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	3,146,898	21,726	45,488	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476		21,726	15,692	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316		21,726	15	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811		21,726	17	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720		21,726	1,547	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141		21,726	130	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			21,726		20
21	30	Depreciation	Resident Days	1,572,338	77	212,800		21,726	199	21
22	32	Interest	Resident Days	1,572,338	77	135,328		21,726	264	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451		21,726	112	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540		21,726	347	24
25	TOTALS					\$ 8,517,291	\$ 8,113,127		\$ 128,441	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$			\$	9				
	B. Non-Facility Related*															
10									Home Office Allocation-PHCM		264	10				
11									Interest Income Offset		(116)	11				
12									Home Office Allocation-PHC		1,870	12				
13									Home Office Allocation-MHO			13				
14	TOTAL Non-Facility Related						\$	\$			\$ 2,018	14				
15	TOTALS (line 9+line14)						\$	\$			\$ 2,018	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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 2013 report.			\$ <u>31,656</u>	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.)	2013		\$ <u>30,666</u>	2															
3. Under or (over) accrual (line 2 minus line 1).			\$ <u>(990)</u>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <u>31,584</u>	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.			256																
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation	\$	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <u>30,850</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>30,661</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>31,129</u>	9																
	2011	<u>31,052</u>	10																
	2012	<u>30,729</u>	11																
	2013	<u>30,666</u>	12																
<u>Accrual based on prior year tax bill.</u>																			

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aledo Rehab & Hlth Care Ctr COUNTY Mercer
 FACILITY IDPH LICENSE NUMBER 0051300
 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-10-20-302-002</u>	<u>Long-Term Care Facility</u>	\$ <u>30,665.52</u>	\$ <u>30,665.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>30,665.52</u></u>	\$ <u><u>30,665.52</u></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 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 & Hlth Care Ctr

0051300 Report Period Beginning:

1/1/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,378 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 329,179	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	2,159	10
11	Carpet		2005	1,681		10	168	168	1,358	11
12	Sidewalks		2006	9,946		20	497	497	3,728	12
13	Sidewalks		2006	20,675		20	1,034	1,034	7,755	13
14	Boiler System		2007	16,250		15	1,083	1,083	7,040	14
15	Alarm System		2007	1,003		10	100	100	650	15
16	Kitchen Drain Line		2008	5,968		25	238	238	1,309	16
17	Water Heater		2009	6,200		5	1,240	1,240	5,580	17
18	Generator Repair		2009	4,413		7	630	630	2,796	18
19	Asphalt Resurfacing		2009	19,335		10	1,934	1,934	8,703	19
20	Sprinkler Repair System		2010	5,370		7	768	768	2,688	20
21	Painting of Exterior of Facility		2010	7,077		15	472	472	1,652	21
22	Rooftop A/C Unit		2011	6,781		15	452	452	1,130	22
23	Retaining Wall		2011	4,285		15	286	286	715	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

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

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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								60
61								61
62								62
63					3,975		(3,975)	63
64					34,053		(34,053)	64
65					3,127		(3,127)	65
66								66
67		10,142			243		243	67
68		947			52		52	68
69								69
70		\$ 1,146,908	\$ 41,155		\$ 43,504	\$ 2,349	\$ 379,140	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	\$ 324,319	\$ 22,046	\$ 32,673	\$ 10,627	5-10 yrs.	\$ 302,562	71
72	Current Year Purchases	8,241	1,177	1,177		10 yrs.	1,971	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,120	5,120			74
75	TOTALS	\$ 332,560	\$ 23,223	\$ 38,970	\$ 15,747		\$ 304,533	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										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)	\$ 1,529,468	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,378	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,474	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,096	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 683,673	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					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr

0051300

Report Period Beginning: 1/1/14

Ending: 12/31/14

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 14,287 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Aledo Health and Rehabilitation Center

0047142

Period Beginning 1/1/2014

Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 7,999
Dishwasher	936
Laundry Equipment	170
Copier	4,095
Home Office Allocation	<u>1,087</u>
	<u><u>14,287</u></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>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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,438	\$ 81,575	\$	5,438	\$ 81,575	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		238	3,577		238	3,577	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,166	62,496		4,166	62,496	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				19,510		19,510	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			\$	9,843	\$ 147,648	\$ 19,510	9,843	\$ 167,158	14

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

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

0051300

Report Period Beginning: **1/1/14**

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/14** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 253,842	\$ 253,842	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 197,703)	481,765	481,765	3
4	Supply Inventory (priced at Cost)	10,057	10,057	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,975	28,975	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(238)	(238)	8
9	Other(specify): Employee Education Loans			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 774,401	\$ 774,401	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	1,031,742	14
15	Leasehold Improvements, at Historical Cost	48,013	115,166	15
16	Equipment, at Historical Cost	332,559	332,560	16
17	Accumulated Depreciation (book methods)	(681,989)	(683,673)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 820,139	\$ 845,795	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,594,540	\$ 1,620,196	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 470,966	\$ 470,966	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,744	97,744	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,155	33,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,584	31,584	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Payroll Withholdings	94,914	94,914	36
37	Accrued Management Fees	227,138	227,138	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 955,501	\$ 955,501	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	Due To Due From	10,802	10,802	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,802	\$ 10,802	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 966,303	\$ 966,303	46
47	TOTAL EQUITY(page 18, line 24)	\$ 628,237	\$ 653,893	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,594,540	\$ 1,620,196	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 522,269	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 522,269	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,968	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)	\$ 105,968	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)	\$ 628,237	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,683,417	1
2	Discounts and Allowances for all Levels	(101,046)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,582,371	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,939	6
7	Oxygen	971	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 233,910	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,785	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,023	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,901	20
21	Other Medical Services	6,393	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,102	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	116	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 116	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	687	28
28a	Transportation Revenue	117	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 804	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,862,303	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	612,147	31
32	Health Care	1,286,052	32
33	General Administration	407,367	33
B. Capital Expense			
34	Ownership	118,370	34
C. Ancillary Expense			
35	Special Cost Centers	151,176	35
36	Provider Participation Fee	181,223	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,756,335	40
41	Income before Income Taxes (line 30 minus line 40)**	105,968	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 105,968	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,625,936	44
45	Private Pay - Net Inpatient Revenue	809,681	45
46	Medicare - Net Inpatient Revenue	152,228	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(5,474)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,582,371	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** 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 & Hlth Care Ctr**

0051300

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	\$ 59,646	\$ 28.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,626	7,974	189,753	23.80	3
4	Licensed Practical Nurses	10,771	11,396	231,737	20.33	4
5	CNAs & Orderlies	34,936	36,604	465,457	12.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,262	4,527	42,611	9.41	10
11	Social Service Workers	1,942	1,997	22,587	11.31	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,560	23,167	14.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,978	12,525	112,589	8.99	15
16	Dishwashers					16
17	Maintenance Workers	1,950	2,062	31,277	15.17	17
18	Housekeepers	9,313	9,664	85,841	8.88	18
19	Laundry	2,728	2,848	25,381	8.91	19
20	Administrator	2,080	2,080	52,539	25.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,001	2,057	22,001	10.70	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	5,655	5,796	97,641	16.85	33
34	TOTAL (lines 1 - 33)	98,880	103,170	\$ 1,462,227 *	\$ 14.17	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 4,557	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)	\$ 10,557		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Aledo Health and Rehabilitation Center
0047142
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs.	# of Hrs.	Reportin g Period Total	Average
	Actually	Paid and	Salaries,	Hourly
	Worked	Accrued	Wages	Wage
Care Plan Coordinator	1,862	2,003	50,463	25.19
Transportation	1,713	1,713	16,580	14.71
Marketing	2,080	2,080	30,598	9.68
TOTAL	5,655	5,796	97,641	

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	
Scott Widener	Administrator	0	\$ 52,539	Workers' Compensation Insurance	\$ 38,864	IDPH License Fee	\$	
				Unemployment Compensation Insurance	48,857	Advertising: Employee Recruitment		
				FICA Taxes	102,092	Health Care Worker Background Check		
				Employee Health Insurance	3,464	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	23 230	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	150	
				Employee Relations	5,002	Miscellaneous Dues & Subscriptions	0	
				Employee Retirement	(25)	Home Office Allocation	425	
				Home Office Allocation	17,329			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,539	TOTAL (agree to Schedule V, line 22, col.8)		\$ 805		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 129,400				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 129,400	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Amount	
E-Health Data Solutions	Computer Services	\$ 2,221					Out-of-State Travel \$	
Frontier	Computer Services	731						
Mediacom	Computer Services	1,548		N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation 28	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 4,500	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8) \$ 28

* Attach copy of IMRF notifications

**See instructions.

Aledo Rehab & Hlth Care Ctr
0051300
Period Beginning
Period End

1/1/2014
12/31/2014

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,500
Home Office Allocation		
Lexis Nexis	Legal	7
GoffWilson	Legal	506
Illinois Secretary of State	Legal	46
Bank of America	Legal	153
Healthcare Resources International	Legal	92
Miscellaneous	Legal	20
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	15
Black, Hedin, Ballard	Legal	27
SmithAmundsen	Legal	27
CliftonLarson Allen	Accountants	1,077
Ginoli & Co.	Accountants	2,256
Miscellaneous	Computer Services	20
Odessian LLC	Computer Services	6
Optimizer	Computer Services	43
Allpayer Exchange	Computer Services	14
CCH	Computer Services	23
Prism Software	Computer Services	68
Macquarie Technology Services	Computer Services	60
Advanced Answers on Demand	Computer Services	3,191
Stratus Networks	Computer Services	420
Kemper Technology	Computer Services	1,450
AT&T	Computer Services	5
Ability Network	Computer Services	482
Barracuda	Computer Services	110

CIAN	Computer Services	131
Comcast	Computer Services	33
Emdeon	Computer Services	85
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	4
David Budde	Other Prof Fees	37
All Scripts	Other Prof Fees	25
Miscellaneous	Other Prof Fees	5
Marotta Gund Budd Derza	Other Prof Fees	9,281

Total (agree to Schedule V, line 19, column 8)	<u>24,243</u>
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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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,672 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. \$ 181,223
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,785
- (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. \$ 687
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Adquate 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.