FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053942

Facility Name: Aledo Rehab & Hlth Care Ctr

Address: 304 SW 12th Street (Number) Aledo (City) 61231 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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)	(Date)
	(Type or Print Name)	Mark B. Petersen
	(Title)	Chief Executive Officer
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone) ( )	Fax # ( )

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
Email Address:

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 Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	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	13,180	7,674	721	21,575	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,180	7,674	721	21,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.89%

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 [X] 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 [X] Date 5/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 642

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	134,624	12,824		147,448		147,448	4,432	151,880			1
2	Food Purchase		157,003		157,003		157,003	(2,080)	154,923			2
3	Housekeeping	72,449	19,763		92,212		92,212	77	92,289			3
4	Laundry	36,711	12,565		49,276		49,276		49,276			4
5	Heat and Other Utilities			66,767	66,767		66,767	258	67,025			5
6	Maintenance	31,904	10,236	22,760	64,900		64,900	2,420	67,320			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	275,688	212,391	89,527	577,606		577,606	5,107	582,713			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,036,280	42,844	3,950	1,083,074		1,083,074	131	1,083,205			10
10a	Therapy			73,151	73,151		73,151		73,151			10a
11	Activities	61,300		43	61,343		61,343	(225)	61,118			11
12	Social Services	22,180			22,180		22,180		22,180			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,119,760	42,844	83,144	1,245,748		1,245,748	(94)	1,245,654			16
	C. General Administration											
17	Administrative			209,600	209,600		209,600	(152,600)	57,000			17
18	Directors Fees											18
19	Professional Services			5,754	5,754		5,754	12,652	18,406			19
20	Dues, Fees, Subscriptions & Promotions			3,817	3,817		3,817	472	4,289			20
21	Clerical & General Office Expenses	23,176	888	11,565	35,629		35,629	51,387	87,016			21
22	Employee Benefits & Payroll Taxes			180,813	180,813		180,813	28,888	209,701			22
23	Inservice Training & Education							99	99			23
24	Travel and Seminar							48	48			24
25	Other Admin. Staff Transportation			9,113	9,113		9,113	4,064	13,177			25
26	Insurance-Prop.Liab.Malpractice			24,640	24,640		24,640	573	25,213			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	23,176	888	445,302	469,366		469,366	(54,417)	414,949			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,418,624	256,123	617,973	2,292,720		2,292,720	(49,404)	2,243,316			29

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

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr #0053942 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			53,420	53,420		53,420	10,947	64,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							164	164			32
33	Real Estate Taxes			30,302	30,302		30,302	263	30,565			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,967	7,967		7,967	930	8,897			35
36	Other (specify):*											36
37	**TOTAL Ownership**			91,689	91,689		91,689	12,304	103,993			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,223		16,223		16,223		16,223			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			170,332	170,332		170,332		170,332			42
43	Other (specify):*	31,825		41,597	73,422		73,422	(73,422)				43
44	**TOTAL Special Cost Centers**	31,825	16,223	211,929	259,977		259,977	(73,422)	186,555			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,450,449	272,346	921,591	2,644,386		2,644,386	(110,522)	2,533,864			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 # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	(2,160)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,700)	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	(486)	30		9
10	Interest and Other Investment Income	(172)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	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	(17,318)	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	(6,000)	43		24
25	Fund Raising, Advertising and Promotional	(33,226)	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	(6,548)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,742)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 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)	(33,780)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,780)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (110,522)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Aledo Rehab & Hlth Care Ctr

ID# 0053942

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,003)	43	1
2	X-Rays-Part A	(1,043)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(277)	21	3
4	Offset Transportation Revenue	(225)	11	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
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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**	(6,548)		49

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	4,432	0	0	0	0	0	0	0	0	0	4,432	1
2	Food Purchase	(2,160)	80	0	0	0	0	0	0	0	0	0	(2,080)	2
3	Housekeeping	0	77	0	0	0	0	0	0	0	0	0	77	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	258	0	0	0	0	0	0	0	0	0	258	5
6	Maintenance	0	2,420	0	0	0	0	0	0	0	0	0	2,420	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,160)	7,267	0	0	0	0	0	0	0	0	0	5,107	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	131	0	0	0	0	0	0	0	0	0	131	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(225)	0	0	0	0	0	0	0	0	0	0	(225)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(225)	131	0	0	0	0	0	0	0	0	0	(94)	16
	C. General Administration													
17	Administrative	0	(152,600)	0	0	0	0	0	0	0	0	0	(152,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,286	0	1,366	0	0	0	0	0	0	0	12,652	19
20	Fees, Subscriptions & Promotions	0	0	472	0	0	0	0	0	0	0	0	472	20
21	Clerical & General Office Expenses	(277)	0	51,664	0	0	0	0	0	0	0	0	51,387	21
22	Employee Benefits & Payroll Taxes	0	0	28,888	0	0	0	0	0	0	0	0	28,888	22
23	Inservice Training & Education	0	0	99	0	0	0	0	0	0	0	0	99	23
24	Travel and Seminar	0	0	48	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	0	0	4,064	0	0	0	0	0	0	0	0	4,064	25
26	Insurance-Prop.Liab.Malpractice	0	0	573	0	0	0	0	0	0	0	0	573	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(277)	(141,314)	85,808	1,366	0	0	0	0	0	0	0	(54,417)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,662)	(133,916)	85,808	1,366	0	0	0	0	0	0	0	(49,404)	29

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(486)	0	11,433	0	0	0	0	0	0	0	0	10,947	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(172)	0	336	0	0	0	0	0	0	0	0	164	32
33	Real Estate Taxes	0	0	263	0	0	0	0	0	0	0	0	263	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	930	0	0	0	0	0	0	0	0	930	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(658)	0	12,962	0	0	0	0	0	0	0	0	12,304	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(73,422)	0	0	0	0	0	0	0	0	0	0	(73,422)	43
44	**TOTAL Special Cost Centers**	(73,422)	0	0	0	0	0	0	0	0	0	0	(73,422)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(76,742)	(133,916)	98,770	1,366	0	0	0	0	0	0	0	(110,522)	45

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. [X] 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 Management, Inc.	100.00%	$ 4,432	$ 4,432	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	80	80	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	77	77	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	258	258	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,420	2,420	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	131	131	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	209,600	Petersen Health Care Management, Inc.	100.00%	57,000	(152,600)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,286	11,286	12
13	V								13
14	Total			$ 209,600			$ 75,684	$ * (133,916)	14

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. [X] 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 Management, Inc.	100.00%	$ 472	$ 472	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	51,664	51,664	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	28,888	28,888	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	99	99	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	48	48	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,064	4,064	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	573	573	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	11,433	11,433	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	336	336	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	263	263	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	930	930	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			$			$ 98,770	$ * 98,770	39

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. X 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 Group, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Group, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Group, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Group, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Group, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Group, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Group, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Group, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Group, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Group, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Group, LLC	100.00%	1,366	1,366	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Group, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Group, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Group, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Group, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Group, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Group, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Group, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Group, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Group, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Group, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Petersen Health Group, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Group, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Group, LLC	100.00%	0		38
39	Total			$			$ 1,366	$ * 1,366	39

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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 X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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 Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 X 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 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	1,521,544	75	$ 312,540	$ 357,910	21,575	$ 4,432	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	21,575	80	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	21,575	77	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	21,575	258	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	21,575	2,420	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	21,575	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	21,575	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	21,575	131	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	21,575	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	21,575	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	21,575	57,000	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	21,575	11,286	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	21,575	472	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	21,575	51,664	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	21,575	28,888	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	21,575	99	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	21,575	48	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	21,575	4,064	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	21,575	573	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	21,575	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	21,575	11,433	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	21,575	336	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	21,575	263	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	21,575	930	24
25	TOTALS					$ 13,089,501	$ 11,510,481		$ 174,454	25

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 X NO

Name of Related Organization: Petersen Health Group
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 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	45,487	2	$	$	21,575	$	1
2	2	Food	Resident Days	45,487	2			21,575		2
3	3	Housekeeping	Resident Days	45,487	2			21,575		3
4	4	Laundry	Resident Days	45,487	2			21,575		4
5	5	Utilities	Resident Days	45,487	2			21,575		5
6	6	Maintenance	Resident Days	45,487	2			21,575		6
7	7	Mgmt. Allocation of Benefits	Resident Days	45,487	2			21,575		7
8	10	Nursing and Medical Records	Resident Days	45,487	2			21,575		8
9	15	Mgmt. Allocation of Benefits	Resident Days	45,487	2			21,575		9
10	17	Administrative	Resident Days	45,487	2			21,575		10
11	19	Professional Services	Resident Days	45,487	2	2,880		21,575	1,366	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	45,487	2			21,575		12
13	21	Clerical and General Office	Resident Days	45,487	2			21,575		13
14	22	Employee Benefits & Payroll	Resident Days	45,487	2			21,575		14
15	23	Inservice Training & Education	Resident Days	45,487	2			21,575		15
16	24	Travel and Seminar	Resident Days	45,487	2			21,575		16
17	25	Other Admin. Staff Transport.	Resident Days	45,487	2			21,575		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	45,487	2			21,575		18
19	30	Depreciation	Resident Days	45,487	2			21,575		19
20	31	Amortization	Resident Days	45,487	2			21,575		20
21	32	Interest	Resident Days	45,487	2			21,575		21
22	33	Real Estate Taxes	Resident Days	45,487	2			21,575		22
23	34	Rent-Facility and Grounds	Resident Days	45,487	2			21,575		23
24	35	Rent-Equipment & Vehicles	Resident Days	45,487	2			21,575		24
25	TOTALS					$ 2,880	$		$ 1,366	25

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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							$	$			$	1
2	N/A											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			336	10
11								Interest Income Offset			(172)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 164	14
15	TOTALS (line 9+line14)						$	$			$ 164	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** ____________ **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.)**

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 2015 report.	$	31,704	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.)	$	30,542	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,162)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,464	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** **TOTAL REFUND $** ______ **For** ______ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	263	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	30,565	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	31,052	8
	2012	30,729	9
	2013	30,666	10
	2014	30,777	11
	2015	30,542	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aledo Rehab & Hlth Care Ctr COUNTY Mercer

FACILITY IDPH LICENSE NUMBER 0053942

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	10-10-20-302-002	Long-Term Care Facility	$ 30,542.28	$ 30,542.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,542.28	$ 30,542.28

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: ______ B. General Construction Type: Exterior ______ Frame ______ Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 397,285	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	124	124	2,537	10
11	Carpet			2005	1,681		10	155	155	1,681	11
12	Sidewalks			2006	9,946		20	497	497	4,722	12
13	Sidewalks			2006	20,675		20	1,034	1,034	9,823	13
14	Boiler System			2007	16,250		15	1,083	1,083	9,206	14
15	Alarm System			2007	1,003		10	100	100	850	15
16	Kitchen Drain Line			2008	5,968		25	238	238	1,785	16
17	Water Heater			2009	6,200		5	620	620	6,200	17
18	Generator Repair			2009	4,413		7	630	630	4,056	18
19	Asphalt Resurfacing			2009	19,335		10	1,934	1,934	12,571	19
20	Sprinkler Repair System			2010	5,370		7	768	768	4,224	20
21	Painting of Exterior of Facility			2010	7,077		15	472	472	2,596	21
22	Rooftop A/C Unit			2011	6,781		15	452	452	2,034	22
23	Retaining Wall			2011	4,285		15	286	286	1,287	23
24	Water Heater			2015	4,020		7	574	574	861	24
25	Water Pipe Repair			2015	4,883		7	349	349	349	25
26	Flooring Tile Install-TV Room, 3 Bathrooms, Front Hallways			2016	67,424		15	2,247	2,247	2,247	26
27	Piping Replacement Through Building, New Water Heater			2016	63,986		15	2,133	2,133	2,133	27
28											28
29											29
30	Land Improvements Booked					3,975			(3,975)		30
31	Building Booked					34,053			(34,053)		31
32	Building Improvement Booked					10,788			(10,788)		32
33											33
34	2016-Home Office Allocation-Building Improvements				9,525			229	229		34
35	2016-Home Office Allocation-Land Improvements				876			57	57		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 # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,286,533	$ 48,816		$ 48,035	$ (781)	$ 469,145	70

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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 52,772	$ 4,375	$ 5,014	$ 639	5-10 yrs.	$ 30,741	71
72	Current Year Purchases	2,400	229	171	(58)	7 yrs.	171	72
73	Fully Depreciated Assets	289,665					289,665	73
74	Home Office Allocation			11,147	11,147			74
75	TOTALS	$ 344,837	$ 4,604	$ 16,332	$ 11,728		$ 320,577	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 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)	$ 1,681,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,420	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,367	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,947	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 789,722	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 8,897 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

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

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

Aledo Rehab & Hlth Care Ctr
0053942
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	4,251
Dishwasher		701
Copier		3,015
Home Office Allocation		930
		8,897

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,143	$ 32,145	$	2,143	$ 32,145	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		332	4,985		332	4,985	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,401	36,021		2,401	36,021	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 prescrpts				16,223		16,223	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			$	4,876	$ 73,151	$ 16,223	4,876	$ 89,374	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 # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ (45,380)	$ (45,380)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 138,565)	1,220,650	1,220,650	3
4	Supply Inventory (priced at Cost)	10,057	10,057	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,137	23,137	6
7	Other Prepaid Expenses	188	188	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	15	15	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,208,667	$ 1,208,667	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	1,031,125	14
15	Leasehold Improvements, at Historical Cost	188,326	255,408	15
16	Equipment, at Historical Cost	344,837	344,837	16
17	Accumulated Depreciation (book methods)	(800,898)	(789,722)	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)**	$ 853,821	$ 891,648	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,062,488	$ 2,100,315	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 367,792	$ 367,792	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,234	95,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	120,934	120,934	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,464	31,464	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	189,932	189,932	36
37	Accrued Management Fees	365,981	365,981	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,171,337	$ 1,171,337	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	Intercompany Loans	83,331	83,331	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 83,331	$ 83,331	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,254,668	$ 1,254,668	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 807,820	$ 845,647	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,062,488	$ 2,100,315	48

*(See instructions.)

Facility Name & ID Number **Aledo Rehab & Hlth Care Ctr** **#** **0053942** **Report Period Beginning:** **1/1/2016** **Ending:** **12/31/2016**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 571,314	1
2	Restatements (describe):		2
3	**Prior Period Adjustment Made After Cost Report Was Filed**	(14,998)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 556,316	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	251,504	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)**	$ 251,504	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)**	$ 807,820	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,762,851	1
2	Discounts and Allowances for all Levels	(49,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,713,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,096	6
7	Oxygen	35	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 133,131	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	2,160	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,731	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,020	20
21	Other Medical Services	14,128	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	172	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 172	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	225	28
28a	Miscellaneous Revenue	277	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 502	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,895,890	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	577,606	31
32	Health Care	1,245,748	32
33	General Administration	469,366	33
	B. Capital Expense		
34	Ownership	91,689	34
	C. Ancillary Expense		
35	Special Cost Centers	89,645	35
36	Provider Participation Fee	170,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,644,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	251,504	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 251,504	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,651,251	44
45	Private Pay - Net Inpatient Revenue	890,912	45
46	Medicare - Net Inpatient Revenue	154,047	46
47	Other-(specify) Insurance Net Inpatient Revenue	16,836	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,713,046	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 # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 61,204	$ 29.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,901	6,292	153,638	24.42	3
4	Licensed Practical Nurses	11,990	12,424	255,438	20.56	4
5	CNAs & Orderlies	39,819	41,305	508,813	12.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	84	84	848	10.10	8
9	Activity Director					9
10	Activity Assistants	4,778	4,835	43,813	9.06	10
11	Social Service Workers	1,810	1,935	22,180	11.46	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,000	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,022	11,546	108,624	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,994	2,026	31,904	15.75	17
18	Housekeepers	8,313	8,682	72,449	8.34	18
19	Laundry	3,930	4,124	36,711	8.90	19
20	Administrator	2,000	2,080	57,000	27.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,155	2,259	23,176	10.26	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	1,931	2,067	56,339	27.26	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Transportation	1,734	1,774	17,487	9.86	32
33	Other(specify) Marketing	2,080	2,080	31,825	15.30	33
34	TOTAL (lines 1 - 33)	103,701	107,673	$ 1,507,449 *	$ 14.00	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	4,702	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	834	L10, C3	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)	16	$ 11,536		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

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Scott Widener	Administrator	0	$	57,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	57,000

B. Administrative - Other

Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$	209,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	209,600

C. Professional Services

Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services	$	2,941
Frontier	Computer Services		670
Mediacom	Computer Services		1,624
Ability Network	Computer Services		102
Tazewell Co Recorder	Filing Fees		2
Pro Title USA	Legal Fees		322
Mercer County Circuit Clerk	Filing Fees		40
Wells Fargo	Filing Fees		53
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	5,754

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	27,072
Unemployment Compensation Insurance		43,875
FICA Taxes		105,037
Employee Health Insurance		4,279
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Relations		550
Home Office Allocation		28,888
TOTAL (agree to Schedule V, line 22, col.8)	$	209,701

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #		Amount
N/A			
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	1,429
Advertising: Employee Recruitment		
Health Care Worker Background Check		
(Indicate # of checks performed 88)		0
Patient Background Checks 33		87
Miscellaneous Licenses & Permits		1,301
Miscellaneous Dues & Subscriptions		1,000
Home Office Allocation		472
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	4,289

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		
Home Office Allocation		48
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	48

**See instructions.

Aledo Rehab & Hlth Care Ctr
0053942

Period Beginning	**1/1/2016**
Period End	**12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		5,754
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	50
Miscellaneous	Legal	21
Miller Hall and Triggs	Legal	87
Healthcare Resources International	Legal	435
Hunziker Law	Legal	104
Lexis Nexis	Legal	9
CliftonLarson Allen	Accountants	452
Ginoli & Co.	Accountants	2843
Miscellaneous	Computer Services	57
Change Healthcare	Computer Services	8
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	3973
Stratus Networks	Computer Services	404
Kemper Technology	Computer Services	266
AT&T	Computer Services	6
Ability Network	Computer Services	1694
CIAN	Computer Services	202
Comcast	Computer Services	33
CCH	Computer Services	13
Charter Communications	Computer Services	39
Allscripts	Computer Services	591
ATS	Computer Services	266
Allpayer Exchange	Computer Services	13
Optimizer	Other Prof Fees	41
Ankura	Other Prof Fees	308
David Budde	Other Prof Fees	35
Bruner, Cooper, Zuck	Other Prof Fees	90
Marotta, Gund, Budd, Dzerda	Other Prof Fees	555
Professional Software and Services	Other Prof Fees	22
Hughes Valuation Services	Other Prof Fees	28
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		18,406

Facility Name & ID Number Aledo Rehab & Hlth Care Ctr # 0053942 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$1000**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,019** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **170,332**
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. $ **2,160**

(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. $ **225**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

RECONCILIATION REPORT **Aledo Rehab & Hlth Ca** 09:05 AM 7/7/2017

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-110,522	equal to	-110,522	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	164	equal to	164	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	30,565	equal to	30,565	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,367	equal to	64,367	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,897	equal to	8,897	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	73,151	equal to	73,151	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	16,223	equal to	16,223	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	577,606	equal to	577,606	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,245,748	equal to	1,245,748	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	469,366	equal to	469,366	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	91,689	equal to	91,689	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	89,645	equal to	89,645	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	170,332	equal to	170,332	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,036,280	equal to	1,036,280	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	61,300	equal to	61,300	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,180	equal to	22,180	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	134,624	equal to	134,624	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,904	equal to	31,904	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	72,449	equal to	72,449	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	36,711	equal to	36,711	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	57,000	equal to	57,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	23,176	equal to	23,176	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,507,449	equal to	1,450,449	57,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	5,536	< or = to	3,950	1,586	FAILED	Pg20 X14..X16+	B. & C.	:7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	43	-43	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	57,000	equal to	57,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	209,600	equal to	209,600	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	5,754	equal to	5,754	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	209,701	equal to	209,701	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,289	equal to	4,289	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	48	equal to	48	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	170,332	equal to	170,332	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	642	equal to	721	-79	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-33,780	equal to	-33,780	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	31,464	equal to	31,464	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,286,533	equal to	1,286,533	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	344,837	equal to	344,837	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	789,722	equal to	789,722	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	807,820	equal to	807,820	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	251,504	equal to	251,504	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..:	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,062,488	equal to	2,062,488	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED**
TO THE COST REPORT!!!! 7/7/2017 09:05:09 AM

HSA Number: 4 Name: **Aledo Rehab & Hlth Care Ctr**

Cost report peri From: 1/1/2016 To: 12/31/2016 Base Number: 492
If this is an ICF/DD 16 facility, e N
Licensed bed d 29,200 Occupancy: 21,575 Pct. of occupan 73.89%

ublic Aid Support Rate: $ ______

Genl Services S	275,688	Col 1, Line 8 ---Audit Adj:	______
Genl Admin Sal	23,176	Col 1, Line 28 ---Audit Adj:	______
Total Salary Wa	1,450,449	Col 1, Line 44 ---Audit Adj:	______
Employee Bene	209,701	Col 8, Line 22 ---Audit Adj:	______
Total General S	582,713	Col 8, Line 8 ---Audit Adj:	______
Total General A	414,949	Col 8, Line 28 ---Audit Adj:	______

Instructions and Calculation Steps:

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

[illegible]

A. General Services

[illegible]

B. General Administration

[illegible]

STEP II Adjust Support Service Costs for Inflation

[illegible]

A. Base Number Calculation

[illegible]

B. Select the Appropriate Inflation Multipliers

[illegible]

General Services Multiplier 1
General Administration Multiplier 1

C. Apply Inflation Multipliers to Update Cost

[illegible]

New Total General Service Cost (Step I-A)	$622,571	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$622,571

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$208,599	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$208,599
3 Total Updated Support Costs (1 + 2)		$831,170

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $35.47

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$831,170
Total Patient Days (Cost Report)	21,575
Support Costs per Diem	$38.52

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	29,200
Multiplied by	0.93
	27,156
Minus total Patient Days	21,575
	5,581
One-third of difference	1,860
Plus Total Patient Days	21,575
Adjusted Occupancy	23,435
Total Support Costs (Step II, C, 3, above)	$831,170
Divided by Adjusted Occupany	23435
Support Costs Per Diem	$35.47

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$35.47
Difference	$11.97
Multiply the Difference by	0.5
One-Half of the Difference	$5.99
Plus Support Costs Per Diem	$35.47
Support Rate if costs are between 35th and 75th percentile	41.46

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$35.47
Difference	$11.97
Multiply the Difference by	0.5
One-Half of the Difference	$5.99
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$3.795
Plus Support Costs Per Diem	$35.47
Support Rate if support costs less than 35th percentile	$39.27

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$39.27**

75th Percentile is $47.44
35th Percentile is $39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	134,624	12,824	0	147,448	0	147,448	4,432	151,880
2. Food Purchase	0	157,003	0	157,003	0	157,003	-2,080	154,923
3. Housekeeping	72,449	19,763	0	92,212	0	92,212	77	92,289
4. Laundry	36,711	12,565	0	49,276	0	49,276	0	49,276
5. Heat and Other Utilities	0	0	66,767	66,767	0	66,767	258	67,025
6. Maintenance	31,904	10,236	22,760	64,900	0	64,900	2,420	67,320
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	275,688	212,391	89,527	577,606	0	577,606	5,107	582,713
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	1,036,280	42,844	3,950	1,083,074	0	1,083,074	131	#######
10a. Therapy	0	0	73,151	73,151	0	73,151	0	73,151
11. Activities	61,300	0	43	61,343	0	61,343	-225	61,118
12. Social Services	22,180	0	0	22,180	0	22,180	0	22,180
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,119,760	42,844	83,144	1,245,748	0	1,245,748	-94	#######
17. Administrative	0	0	209,600	209,600	0	209,600	-152,600	57,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,754	5,754	0	5,754	12,652	18,406
20. Fees, Subscriptions & Promotion	0	0	3,817	3,817	0	3,817	472	4,289
21. Clerical & General Office	23,176	888	11,565	35,629	0	35,629	51,387	87,016
22. Employee Benefits & Payroll	0	0	180,813	180,813	0	180,813	28,888	209,701
23. Inservice Training & Education	0	0	0	0	0	0	99	99
24. Travel and Seminar	0	0	0	0	0	0	48	48
25. Other Admin. Staff Trans	0	0	9,113	9,113	0	9,113	4,064	13,177
26. Insurance-Prop.Liab.Malpractice	0	0	24,640	24,640	0	24,640	573	25,213
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	23,176	888	445,302	469,366	0	469,366	-54,417	414,949
29. Total General Administrative	1,418,624	256,123	617,973	2,292,720	0	2,292,720	-49,404	#######
30. Depreciation	0	0	53,420	53,420	0	53,420	10,947	64,367
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	164	164
33. Real Estate	0	0	30,302	30,302	0	30,302	263	30,565
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	7,967	7,967	0	7,967	930	8,897
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	91,689	91,689	0	91,689	12,304	103,993
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	16,223	0	16,223	0	16,223	0	16,223
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	170,332	170,332	0	170,332	0	170,332
43. Other (specify):*	31,825	0	41,597	73,422	0	73,422	-73,422	0
44. Total Special Cost Ce	31,825	16,223	211,929	259,977	0	259,977	-73,422	186,555
45. Grand Total	1,450,449	272,346	921,591	2,644,386	0	2,644,386	-110,522	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-45,380	-45,380
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,220,650	1,220,650
4. Supply Inventory	10,057	10,057
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,137	23,137
7. Other Prepaid Expenses	188	188
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	15	15
10. Total current assets	1,208,667	1,208,667
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	99,956	50,000
14. Buildings, at Historical Cost	1,021,600	1,031,125
15. Leasehold Improvements, Historical Cost	188,326	255,408
16. Equipment, at Historical Cost	344,837	344,837
17. Accumulated Depreciation (book methods)	-800,898	-789,722
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	853,821	891,648
25. Total Assets	2,062,488	2,100,315
CURRENT LIABILITIES		
26. Accounts Payable	367,792	367,792
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	95,234	95,234
31. Accrued Taxes Payable	120,934	120,934
32. Accrued Real Estate Taxes	31,464	31,464
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	189,932	189,932
37. Other Current Liabilities (specify):	365,981	365,981
38. Total Current Liabilities	1,171,337	1,171,337
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	83,331	83,331
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	83,331	83,331
46.Total Liabilities	1,254,668	1,254,668
47.Total Equity	807,820	845,647
48.Total Liabilities and Equity	2,062,488	2,100,315

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,762,851
2. Discounts and Allowances for all Levels	-49,805
Subtotal - Inpatient Care	2,713,046
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	133,096
7. Oxygen	35
Subtotal - Anciliary Revenue	133,131
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,160
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	25,731
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	7,020
21. Other Medical Services	14,128
22. Laundry	0
Subtotal - Other Operating Revenue	49,039
24. Contributions	0
25. Interest and Other Investments Income	172
Subtotal - Non-Operating Revenue	172
27. Other Revenue (specify):	225
28. Other Revenue (specify):	277
Subtotal - Other Revenue	502
30. Total Revenue	2,895,890
31. General Services	90,607
32. Health Care	201,626
33. General Administration	84,657
34. Ownership	17,993
35. Special Cost Centers	-23,705
35. Provider Participation Fee	65,111
37. Other	0
40. Total Expenses	436,289
41. Income Before Income Taxes	2,459,601
42. Income Taxes	0
43. Net Income or Loss for the Year	2,459,601